Maternal and Child Health Services
Title V Block Grant

State Narrative for Maine

Application for 2013
Annual Report for 2011

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

All appropriate Assurances, Non-construction Programs, and Certifications regarding debarment and suspension, drug free work place requirements, lobbying, program fraud civil remedies act, and environmental tobacco smoke are on file in the Maine Center for Disease Control and Prevention's, Division of Population Health and will be made available for review. Requests can be made through email to: Sheri.A.Meucci@maine.gov or by telephone at 207-287-4064.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

MCH programs elicit ongoing public input and consumer representation on committees and in activities. The Children with Special Health Needs (CSHN) and Injury Prevention Programs have successfully engaged youth in planning and advisory capacities resulting in youth oriented materials and activities specific to their needs. The CSHN Program actively involves parents on the advisory committee. Parents and consumers are recognized as critical components of successful programs and their input has been assured through their integration into routine program functions. Families of CSHN and youth are invited to review and comment on the application. Members of the CSHN family and youth advisory councils are also invited to review and comment on the application.

The annual Maternal Child Health Block Grant (MCHBG) planning and reporting processes, as well as, the annual application were discussed with the Joint Advisory Committee (Genetics and CSHN Programs), Newborn Hearing Advisory, School Health Advisory Committee, local WIC directors, medical providers, advocates and annual program and stakeholder meetings with requests made for public input. Consumer, provider, and family input is solicited at every opportunity at public forums such as committee and grantee meetings, conferences, and liaison groups. ***/2013/ No public comments were received. //2013//*** During FY10 the Division of Family Health, widely distributed emails to specific listservs sharing the Title V agency link and asking for input on the comprehensive strengths and needs assessment (CSNA) priority setting process.

A link to TVIS and the MCHBG was added to the Maine CDC home page under the "Data and Reports" tab so visitors to the site can view the application http://www.maine.gov/dhhs/mecdc . For those who visit the Maine CDC website they can access the block grant which contains the Title V Director and CSHN Directors contact information.

The DPH will seek to collaborate with the Maine CDC's Division of Local Public Health (DLPH) to

identify ways to link to and engage local and district level stakeholder input related to maternal and child health. The DPH leadership had discussions with the DLPH leadership on how to include local public health districts in its 5-year CSNA. These discussions led to the DLPH supporting our CSNA by inviting the DPH to include key MCH leaders in local Public Health Service Assessment meetings in each of the 8 DHHS District's and a Tribal Public Health District across the state. These meetings were held to conduct assessments to determine existing resource and service assets in relation to the 10 Essential Public Health Services, as well as, public health needs and gaps in each district.

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Maine's 5 Year CSNA was guided by a quantitative and qualitative analyses. For example, quantitative data (e.g. hospital discharge, YRBS, PRAMS) showed that mental health disorders and violence are important issues affecting the MCH population in Maine. Qualitative data from focus groups also identified mental health and the lack of available services, as well as domestic violence as key needs. As such, we have four priorities related to these areas; child and adolescent mental health, women's mental health, violence against women and childhood exposure to violence. Many of the same concerns are present in both sets of priority needs, but the ways in which the priorities are grouped have changed, indicating a deliberate attempt to be more specific with each priority; a change from 2005 as MCH programs and stakeholders perceived the 2005 priorities to be too broad. There is some overlap between the 2005 and 2010 priorities. The priority needs selected for the 2010 CSNA and those from the 2005 CSNA are outlined below.

Improve Birth Outcomes was replaced with the more specific priorities of family planning and adolescent sexual activity, as well as violence against women, obesity and overweight are all aspects of this broader priority

Improve the safety of the MCH population, including the reduction of intentional and unintentional injuries: The new priorities of intentional self-harm and suicide, violence against women, unintentional injury and childhood exposure to violence are all aspects of this priority

Improve the respiratory health of the MCH population was ranked 16th on the list and replaced by the more specific priorities in other areas

Increase the proportion of the MCH population who are at a healthy weight and physically active was replaced with the new priority of obesity and overweight among children and adults

Improve the mental health system of services and supports for the MCH population was replaced but reflected in two new priorities: Child and adolescent mental health and women's mental health

Foster conditions to improve oral health services and supports for the MCH population was ranked 11th and replaced by the more specific priorities in other areas

Foster the conditions that enable the CSHN Program to move from a direct care focus to a community-based system of care that enables the whole CSHN population to achieve optimal health. This priority did not rank high in the final list, but autism spectrum disorder was selected as the specific CSHN priority. In addition CYSHN will be incorporated into most of the new priorities, specifically: intentional self-harm and suicide, violence against women, family planning, obesity and overweight among children and adults, child and adolescent mental health, women's mental health, unintentional injury, adolescent sexual activity and childhood exposure to violence

Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population. Since this issue was difficult to define and thus hard to implement, it did not rise as a top priority in 2010. During problem mapping, we anticipate that this may be a strategy proposed for a number of the new priorities

Improve cultural and linguistic competence within the system of services for the MCH population:

A similar priority of addressing diversity did not rank high enough for specific inclusion, but it is an underlying value of the MCH program in Maine to address such issues within all of our work. For each priority selected, disparities and culturally competent approaches will be part of the problem analysis

Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs was replaced and reflected in priorities specific to this population (adolescent sexual activity and children and adolescent mental health) as well as a part of other priorities that are not specific to the population, including intentional self-harm and suicide, family planning, violence against women, obesity and overweight among children and adults, unintentional injury, and childhood exposure to violence

The methodology for determining the 2010 priority needs built upon the experience of the 2005 CSNA. In 2005 we set out to ensure all voices were heard and from this process we gained a wealth of information not only from those working with the MCH population but from the consumers seeking services. To compliment the quantitative data, 17 focus groups were held to hear what participants perceived to be the strengths and needs of women, children, adolescents, and families. In addition issue experts from across the broad range of MCH, families and public health professionals, internal and external to Maine CDC and DHHS, were invited to respond to web-based surveys to provide input on narrowing the list of priorities. Fact sheets were developed for the top 30 priorities and reviewed and finalized by issue specific experts. In 2005, the Division of Population Health (DPH), formerly the Division of Family Health, did not solicit this broad input and as such we did not feel that all voices were represented in the priority setting process and that perhaps we were making decisions without having access to a comprehensive set of data.

While we have made many positive strides during the past five years, we continue to be challenged in our work by ongoing state and federal budget reductions. Therefore, the more specific priorities we developed for 2010 will allow us to more closely align our funding with priorities.

The Maine Title V, Five Year CSNA is the first step in a cycle for continuous improvement of MCH health. Beginning in late summer 2010 a strategy mapping process will be initiated to create a road map to address and track the 10 priorities so that we can be better informed on our progress toward improving the overall health of our MCH population. The many partnerships we have fostered over the years will be critical to the MCH Title V Program and our work during the next five years.

/2012/ During FY11 the DPH began a mapping process to develop action plans to improve priorities over the next five years. (See Section IV B for details) Maine's economic downturn continues to challenge the MCH Title V Program's ability to address the needs of our population. Since we completed our CSNA we have had a change in administration that we anticipate may impact the MCH program. State revenues continue to be flat and SFY12 and 13 budgets include reductions in funding for substance abuse, oral health and other programs providing services to the MCH population. The Governor and his cabinet are working with State programs to assess all aspects of State services to assure that the State's limited financial and human resources are being used efficiently and effectively and are focused upon the priority needs. //2012// ***/2013/ A recently approved FY13 budget eliminated Fund for a Healthy Maine (Master Tobacco Settlement) funds for the Maine Families Home Visiting Program in the amount of $2.6 million for FY13. This reduction will severely impact the programs ability to work with many of Maine's first time families who need these valuable services. //2013//***

III. State Overview

A. Overview

Geography

Maine is the northernmost and largest state in New England and the easternmost state in the United States. Maine's population is growing at a slower rate than most of the U.S., but aging at a faster rate. The majority of residents reside in rural towns and small cities. The demographic and geographic factors that contribute to Maine's uniqueness among the New England states are the very same factors that create complex challenges for Maine's Title V agency as we strive to improve the health outcomes of the maternal and child health (MCH) population.

Note: References noted throughout this section are documented in the Comprehensive Strengths and Needs Assessment. The CSNA can be found at the Maine CDC homepage under the "Data and Reports" tab at: http://www.maine.gov/dhhs/mecdc

There are 1.32 million people residing in the state of Maine.(1) Between 2000 and 2008 Maine's overall population increased 3.3% compared to 8% in the U.S. Most of Maine's population growth was due to migration from other states (61.9%) and natural causes (excess births over deaths; 28.6%). However, 11.4% of the growth was due to international migration which has resulted in increased racial and ethnic diversity within the state. In contrast, 63.5% of the U.S. population change in this period was due to net natural increases.(2)

Although 80% of American residents reside in metropolitan areas the majority of Maine's population resides in rural towns and small cities. Statewide 59.8% of the population lives in rural areas as compared with 21% of the US population.(8) More than one third (36.3%) of Maine's population lives in the two southernmost counties (Cumberland and York).(7) However, these counties account for only 6% of the state's land area.(7) In five Maine counties 90% or more of the population lives in rural areas; two of these counties are 100% rural. (9)

Maine has three major cities: Portland (pop. 62,561), Lewiston (pop. 35,131) and Bangor (pop. 31,756).(10) Collectively only 10% of Maine's population resides in these three cities and each city experienced a population decline between 1990 and 2008 (2.8%, 11.6%, and 8.2% respectively). (11) Augusta is the state capital of Maine and has a population of 18,282; Augusta's population has declined by 14% over the past two decades. (11-12)

The average population density of Maine is 42.7 people per square mile compared to 86 people per square mile in the United States. However, the population density of Maine varies dramatically across the state, from 330.4 people per square mile in Cumberland County where Maine's largest city (Portland) is located, to 4.3 people per square mile in Piscataquis County.(7)

The median age of Maine's population is 41.1 years and is the highest in the country.(3) Nationally, the median age is 36.4 years.(3) The U.S. Census Bureau projects that by 2020, 19.1% of Maine's population will be under 18 years and there will be more people age 65 years and older than children under age 18.(4) Between 2005 and 2020 Maine's population of 65 years and older residents will increase by 52.7% while the population under the age of 18 will decrease by 4.8%. Based on census projections Maine's median age will be 46.9 years in 2020 compared to 39 years nationally.(4)

Maine's MCH populations (i.e., children, including those with special health needs and women of reproductive age) represent a significant proportion of the population. In 2008 children under 18 years of age plus women ages 18-44 represented 37.9% of Maine's population of 1.32 million.(1) Children under 18 years of age comprised 20.8% of the state's population. (Nationally, children under age 18 comprised 24.3% of the population.)(1) Across the state's 16 counties the proportion of children ranged from 18.9% to 22.6%.(5)

The median age of women in Maine is 42.2 years.(3) In 2008 women aged 15-44 years comprised 19% of Maine's population, similar to the proportion nationally (20.4%).(1) Across the state the proportion of women of reproductive age within each county ranged from 16.8% to 21.5%.(5)

Prevalence estimates of current disability or special health needs among Maine children range from 10% to 20% depending on the definition used. According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS CSHCN) there were nearly 49,000 CSHCN in Maine, representing 17.7% of children under age 18.(6)

Demographics

Family

According to estimates from the 2005-2007 American Community Surveys (ACS) the average household size in Maine was 2.4 people and the average family size was 2.8.(3) Less than one-third (30.4%) of households in Maine included one or more children under age 18; slightly fewer than in the U.S. (34.6%).(3) Of the households with a child under age 18, 23.3% were female-headed households; 10.8% were male-headed households. Of the households with a child under age 18 nationally, 25.1% were female-headed and 8.4% were male-headed.(3) Of Maine women aged 15 years and over 51% were currently married, 13.4% were divorced, 1.4% were separated, 10.4% were widowed, and 23.7% were never married.(3)

Racial and Ethnic Diversity

According to 2008 Census estimates, Maine's population is 96.4% white (95.3% of Maine's population described themselves as white alone, non-Hispanic), 0.6% American Indian or Alaska Native, 1% black or African-American, 0.9% Asian, and 1.5% two or more races. The Hispanic population is about 1.3%.(13) Of Maine's children under age 18, 91% are non-Hispanic white and 1.8% are Hispanic.(13)

Although Maine's population is predominantly white, the state is gradually becoming more racially diverse. The proportion of the population that is white decreased from 98.4% on the 1990 census to 96.9% on the 2000 census(14) to 96.4% according to the most recent census estimates.(13) Similarly, the proportion of Maine students in public and approved private schools who are white decreased from 97.5% in the 1993-1994 school year to 94.6% in the 2006-2007 academic year. During that school year 2.3% of students were Black or African American, 1.4% were Asian/Pacific Islander, 0.7% were American Indian, and 1% were Hispanic.(15)

Based on 2005-2007 data from the ACS nearly 22,000 Mainers identify as American Indian alone or in combination with one or more other races.(3) There are four federally recognized Indian tribes and five tribal communities in Maine today: Aroostook Band of Micmacs, Houlton Band of Maliseet Indians, Passamaquoddy Tribe of Indian Township, Passamaquoddy Tribe at Pleasant Point, and Penobscot Indian Nation.(16) The majority of Maine's native American population resides in or near the five small, rural communities of Indian Island (Penobscot Nation), Pleasant Point (Passamaquoddy tribe), Indian Township (Passamaquoddy tribe), Houlton (Houlton Band of Maliseet) and Presque Isle (Aroostook Band of Micmac).(17)

A total of 3,369 Passamaquoddy tribal members are listed on the tribal census rolls with 1,364 on the Indian Township census and 2,005 listed on Pleasant Point census.(18) The Aroostook Band of Micmacs is estimated at 1,000 members.(19) The Houlton Band of Maliseet Indians is comprised of approximately 800 members.(20) The Penobscot Nation population is estimated at 2,365 members.(21)

In 2005-2007, 3.2% of Maine residents were foreign-born; the proportion within Maine's counties

ranged from 1.2% to 5.2%.(3) Approximately 30% of Maine's foreign born population was born in North America, 10.3% in Latin America, 27.5% in Europe, 21.3% in Asia, and 10% in Africa. Among Maine's foreign born 77.4% entered the U.S. before 2000. Slightly more than half of Maine's foreign born population are naturalized U.S. citizens (51.1%). Across Maine 7.6% of the population aged five and older spoke a language other than English at home; approximately 1.9% spoke English less than "very well."(3)

Emerging populations in Maine include people of Somali, Sudanese, and Iraqi ancestry arriving in Maine as primary refugees or secondary migrants. Refugees are individuals granted refugee status overseas by the U.S. Department of Homeland Security are brought to the U.S. for resettlement by the U.S. Department of State and are assisted with resettlement in U.S. communities through the Office of Refugee Resettlement and voluntary agencies.(22) In FY08, 60 refugee arrivals were initially resettled in Maine (31 originating from Somalia, 19 from Sudan, and 3 from Iraq).(23) In FY07, there were 118 primary refugees who were resettled in Maine, 142 in FY06, and 151 in FY05.(23) Secondary Migration is a legal term which refers specifically to refugees who are placed for resettlement initially in one location in the United States and who decide to relocate to another part of the United States. Although immigration data does not track secondary migration it is the largest force affecting immigration into Maine. It has been estimated that far more foreign-born arrive in Maine every year through secondary migration than are placed here through federal refugee resettlement placements.(16) For example, beginning around 2001, the number of people with Somali ancestry living in Maine began to steadily increase, both as primary and secondary immigrants, primarily resettling in Lewiston and Portland. The City of Portland's Refugee Service Program estimates that approximately 80% of Maine's immigrant population is due to secondary migration. (16) According to a March 2009 news article, 111 Iraqis have relocated to Maine from other states, and an additional 200 to 300 families are expected to arrive.(24) /2012/ Catholic Charities Maine Refugee and Immigration Services (RIS) has assisted over 12,000 people since its resettlement program began in 1975. In FY10 RIS resettled approximately 300 primary refugees and assisted more than 900 secondary migrants; 215 secondary migrants settled in Lewiston and the remaining 685 in Portland. A conversation with the RIS Resettlement Director on June 21, 2011 revealed that the agency did not have a breakdown of country of origin but estimated the majority are from Somali. //2012//

Educational Attainment

In 2005-2007, 88.8% of Maine residents ages 25 and over were high school graduates compared to 84.9% nationally.(3) The county-specific proportion of residents ages 25 and over who graduated high school ranges from 87.9% to 92.3%.(3) Although a slightly higher percentage of Maine residents over age 25 years have completed high school compared to the U.S. a slightly lower percent have a higher education degree. About one-quarter of Maine residents over age 25 have a bachelor's degree and less than one in 10 (8.9%) completed an advanced degree. (3) Among Maine women 93.2% of those aged 25-34 years and 93.7% of Maine women aged 35-44 years were high school graduates according to data from 2000, the most recent year available; both proportions were higher than that found among women of these age groups in the United States (85.9% and 86.6%, respectively).(25)

Socioeconomic Indicators

Income and Poverty

The Maine Department of Labor's Center for Workforce Research and Information estimated a "livable wage" of what Maine families need to earn to make ends meet taking into account actual living expenses including housing, health care, child care, transportation, and taxes.(26) They estimated that the annual income required for a two-parent (2-earner) two-child Maine family to meet a basic needs budget was $54,384.(26) The county-specific livable wage for this family type ranged from $47,746 (Aroostook County) to $58,515 (Cumberland County). Among one-parent Maine families with one child in pre-school and one in public school the annual income required

was $41,615 with county-specific estimates ranging from $28,504 (Aroostook County) to $45,844 (Cumberland County).(26) The livable wage is considerably higher than both the federal poverty level (FPL) and the income of a minimum wage earner. Maine's $7.50 per hour minimum wage is 25 cents higher than the federal standard. (27, 28) In Maine a full time year-round minimum wage worker will earn $300 per week or $15,600 per year. The national poverty level for a family unit consisting of two people is $14,570 per year.(29) The FPL for a family of four in 2009 was $22,050 and for a family of three was $18,310.(29) As such, while significant portions of the MCH population are under the FPL, even higher proportions live in families that do not earn livable wages.

Based on ACS data the median household income in Maine between 2005-2007 was nearly $5,000 less than in the U.S. overall ($45,211 vs. $50,007).(3) Although states in the Northeast tend to have median incomes above the U.S. median Maine's falls below the U.S. median. There is considerable variation in income across Maine counties. The median household income ranged from $33,171 in Washington County to $53,768 in Cumberland County.(3)

According to the 2007 ACS 16.4% of Maine's population had incomes below 125% of the poverty threshold based on household size, 4.5% had incomes below 50% of the poverty threshold, 7.5% had incomes between 50% and 100% of the threshold, and 4.4% were between 100% to 125% of the threshold. Poverty is inversely related to educational attainment; among females over age 25, 28.8% of those with less than a high school diploma were below the FPL compared to 14.3% of high school graduates, 10.5% of those with some college, and 4.8% of those with a bachelor's degree or higher.(3)

Across Maine 12.8% of residents and 16.3% of children under 18 years lived below the FPL between 2005 and 2007.(3) The county-specific proportions of children under age 18 below the FPL ranged from 11.2% in Hancock County to 28% in Washington County. Among female-headed households with children under 18 years of age 38.9% lived in poverty (U.S.= 36.9%).(3) Approximately one in five (20.4%) families with children under age five were living below poverty and more than half (59.4%) of female-headed households with children under five lived in poverty between 2005-2007; this is slightly higher than similar households in the U.S.(45.5%).(3) ***/2013/ A Margaret Chase Smith Policy Center review of recent US Census figures show that Maine's two-year average poverty rate has increased since the onset of the economic downturn, from 12.4 in 2007-2008 to 12.9 % in 2009-2010. In 2010, 18.2% of Maine children under of the age of 18 were below poverty; the highest rates were in Washington County (30.9%) and lowest were in Cumberland County (13.6%). [Cited 6.5.12] Available from: http://www.mainecommunityaction.org/wp-content/uploads/2010/12/Poverty-Report-Update-Dec-2011.pdf //2013//***

Labor Force and Employment

Maine's civilian labor force was estimated at 705,000 at the end of 2008.(30) The proportion of adults aged 16 to 64 years old in the labor force ranges from 70.1% in Aroostook County to 80.5% in Cumberland County. The proportion of children with all parents in the labor force is 62.9%, and ranges from 50.9% in Sagadahoc County to 71% in Somerset County.(3) Among women ages 16 to 64 years, 71% are in the civilian labor force. Median earnings for females in 2005-2007 were 67% of male earnings ($23,344 vs. $34,392).(3)

Maine, like the rest of the country, has experienced a downturn in the economy. As of February 2010, there were an estimated 58,600 unemployed Mainers or 8.3% of the workforce.(31) In comparison, in 2001, 3.1% were unemployed. According to the Maine Department of Labor (DOL), since January 2008 Maine has lost 32,000 jobs (nonfarm payroll). Job losses have resulted in longer periods of unemployment and the average duration for collecting unemployment compensation has risen from 14.0 to 17.4 weeks.(32) Unemployment figures do not reflect the number of underemployed and those who have become discouraged and stopped looking for work. Based on US Census data, Maine has a larger proportion of its jobs in

education, health care, and retail trade sectors than in the US overall, while a smaller proportion of its jobs are in manufacturing, wholesale trade, and administrative services sectors.(3) ***/2013/ The May 2012 unemployment rate for Maine was 7.4% compared to 7.7% for the same period last year. [cited 6/18/12] Available from: http://www.maine.gov/labor/cwri/laus.html //2013//***

Income Assistance

Between 2005 and 2007 approximately 23.3% of children under the age of 18 were living in households that in the previous 12 months had received Supplemental Security Income, cash public assistance income, or Supplemental Nutrition Assistance Program (SNAP);(3) this proportion varied by family type. Among children living in married couple family households 13.6% had household income from one or more of these sources; among children living in households with a female householder (no husband present) 48.3% had received assistance, and among children living in households with a male householder (no wife present), 34.9% had received assistance from one or more of these sources.(3)

SNAP assistance is one of the most wide-spread low-income benefit programs in Maine. According to recent data approximately 16% of Maine's overall population was receiving food stamps. Preliminary data suggest that monthly food stamp participation increased by 18% between June 2008 and June 2009.(33) The monthly benefit per person averages $94.52 in Maine. According to the Margaret Chase Smith Policy Center at the University of Maine, increases in food stamp use in earlier years (2001-2006) were explained more by changes in the administration of the program, such as increased outreach efforts rather than by increases in the level of need. However, the current increase in food stamp program participation is likely closely related to increased levels of need related to the economic downturn.(34) ***/2013/ The impact of the economic downturn on families is also evidenced in the number of Maine students eligible for free and reduced school lunch with a 13% increase in the number of qualifying students since 2008-09. As of October 1, 2011, a record high 45.9% of Maine school children were eligible for the free and reduced meals program, with more than half of school age children eligible in nine of the state's 16 counties. [Cited 6.5.12] Available from: http://www.mainecommunityaction.org/wp-content/uploads/2010/12/Poverty-Report-Update-Dec-2011.pdf //2013//***

Housing

According to 2005-2007 ACS data 78.5% of Maine's housing units are occupied.(3) Among Maine's 542,424 occupied housing units, 72.9% are owner-occupied and 27.1% are rented.(3) The median gross monthly rent is $650. One-third of renter-occupied units consume 35% or more of the household incomes of renters. Approximately two-thirds of Maine's owner-occupied housing units have mortgages; 15.8% of owner-occupied housing units with mortgages have housing costs which consume 35% or more of the household incomes of owners.(3)

Among Maine's occupied housing units 6.3% have no vehicles available, 32.6% have one vehicle, and 61.1% have two or more vehicles available.(3) Four percent of occupied housing units have no telephone service available. 68.5% of Maine's occupied housing units are detached single-unit structures, and 9.3% are mobile homes. Nearly three of ten housing units (29.1%) were built before 1940.(3)

Finding affordable housing is a challenge for many Maine residents. According to a 2009 Maine State Housing Authority (MSHA) Report on housing costs in Maine, the median price of homes increased 69% between 2000 and 2007 but dropped 17.6% between 2007 and 2009. Maine's median income increased only 20% during the period 2000-2007 and increased only slightly (4.4%) between 2007-2009.(35) The most affordable communities are in the more rural parts of the state (Aroostook, Piscataquis, and Somerset) with the least affordable in the southern and coastal areas.(35) Similarly, rents increased almost twice as fast as income, leaving Aroostook

county as the only affordable place to live.(36) /2012/ A 2010 MSHA report on the use of federal housing funds in Maine revealed that 63% of Maine households are unable to afford a median home price ($177,500) and 55% cannot afford the rent for an average two-bedroom rent ($722) [cited 5/6/11]; Available from: http://www.mainehousing.org/Documents/HousingReports/Report-FederalFunds2010.pdf //2012//

Homelessness

Homeless children are by most accounts among the fastest growing segments of the homeless population. Compared to their peers, homeless children are more likely to have health problems, developmental delays, learning disabilities, emotional difficulties, and mental disorders.

Homelessness has increased significantly in Maine in recent years. ***/2013/ A January 25, 2012 MSHA Point in Time Survey indicated 1050 people identified as homeless, an increase of 13% from 2011. Of those identified, 11% were adult females in families and 18.5% were children. Chronic disability (46%), severe and persistent mental illness (31.2%), and chronic substance abuse (23.9%) were most frequently cited as reasons for homelessness. [Cited 5/29/12] Available from: http://www.mainehousing.org/docs/homeless/report-homelesspointintime2012.pdf?sfvrsn=6 //2013//*** In a January 2009 MSHA report on rural homelessness, providers noted anecdotally seeing an increase in teen parents and young families between the ages of about 16-24 who lack skills needed to live independently thus increasing the burden on shelters. (114)

In 2007, over 7,000 people stayed in Maine's emergency shelters, including domestic violence (DV) shelters.(37) Of the 7,083 people who used emergency shelters 15% used DV shelters, and of the remaining: 47% were adult individuals, 22% were people in families (one or more adults with at least one child under age 18) and 16% were unaccompanied youth (persons age 23 or younger). Maine's emergency shelters and programs served a total of 513 families in 2007 which included 1,543 people of whom 867 were children under age 18. The most common reason for homelessness given by families in shelters was eviction; three in four families staying in shelters were led by a female head of household.(37)

Throughout 2007 Maine's emergency shelters and programs served 1,048 unaccompanied youth; 59% male and 41% female. Approximately 30% of unaccompanied youth were age 17 or under while 37% were age 18 to 20 and 33% age 21 to 23. The most common reasons for homelessness given by unaccompanied youth in shelters were health or safety, substance abuse, lack of employment, housing affordability, and family conflict. Males reported substance abuse as a primary contributor at over twice the rate as females, while females reported family conflict as a primary contributor at a 50% higher rate than males.(37)

Current Political Climate

During the past eight years under the democratic administration of John Elias Baldacci there has been strong support for issues of concern for the MCH population. /2012/ In November 2010 Paul R. LePage was elected Governor and is the first Republican Governor in 16 years. The Republican Party also won leadership of the Maine House and Senate. Maine's congressional delegation remains divided among Republican and Democratic parties with Olympia Snowe (R) and Susan Collins (R) representing Maine in the Senate and Chellie Pingree (D) and Michael Michaud (D) in the House. ***/2013/ Senator Snowe announced in early 2012 that she will be retiring when her term is up in November. //2013//*** One of Governor LePage's leading campaign issues was to decrease state spending that includes reducing the state workforce. Governor LePage has continued the hiring freeze implemented by Governor Baldacci and has included elimination of additional positions in his FY12 budget. We also anticipate the change in administration will impact policies and direction for the state health department and the MCH program. The State Health Director, Dr. Dora Anne Mills was not re-appointed. She was the

Maine CDC Director for nearly fifteen years //2012//.

In 2004 Governor Baldacci merged the Departments of Human Services and Behavioral and Developmental Services to become the Department of Health and Human Services and the new DHHS was mandated to improve services, increase efficiencies, and improve relations with community organizations. The improvement in services, efficiencies, and relations apply to all segments of DHHS from direct and purchased service sections to finance and operations sections. /2012/ Mary Mayhew was appointed Commissioner of DHHS in February 2011. Sheila Pinette, DO was appointed Director of the Maine CDC effective May 1, 2011. //2012// (See Organizational Structure Section III C)

Impact of Welfare Reform on Women and Children

The advent of Title XXI, SCHIP in 1997 prompted changes in insurance coverage in Maine. Maine responded by renaming our Medicaid program to MaineCare, and creating a Medicaid-like Child Health Insurance Program. This state operated insurance program for children, which includes EPSDT, was for ages birth through 18 years in families 200% of the FPL. There is some cost-sharing for the MaineCare Program. Through the MaineCare Member Services Program EPSDT, within the Division of Population Health (DPH), approximately 130,000 children ages 0-20 are served. Expansion of Medicaid and MaineCare not withstanding, there are still serious concerns about the changing composition of our uninsured populations. In addition to the traditional numbers of uninsured working poor, there is a growing number of middle-income earners who cannot afford the escalating cost of premium co-pays required for dependent coverage.

Maine, like so many other states, continues to experience a decrease in state revenues resulting in a state budget shortfall. The most recent cuts have directly impacted service areas, particularly those purchased through the State Medicaid Agency. While enrollment and eligibility for MaineCare services have not been reduced, some services have been limited along with reductions in provider fees. State and federal budget cuts have resulted in changes to MaineCare services that include reductions in children's mental health services, foster care, occupational and physical therapy and rule changes that restrict targeted case management services. Primary Care Case Management eligibility will be expanded to include members with SSI income who are not eligible for Medicare, and participating physicians must oversee and manage care plans for patients with chronic conditions. /2012/ The Governor's biennial budget includes numerous budget initiatives that will impact the MCH population. Areas include oral health, health insurance coverage, support services such as TANF, home visitation and substance abuse treatment //2012// ***/2013/ The FY13 budget passed by the Legislature and signed by the Governor eliminated tobacco settlement funds for home visiting and family planning and about one third of the funds for tobacco prevention; the Medicaid Program (MaineCare) will no longer cover approximately 19,000 childless adults; and there are many reductions in covered services. This is in addition to the FY12 legislation that repealed Dirigo Health and changed insurance requirements. We anticipate that, at best, health outcomes for the MCH population will remain at current levels. The MCH Epi Team will monitor MCHBG performance metrics to assess the long-term impact of these policy changes. //2013//***

Statewide Health Care Delivery System (County and Local Health Departments)

Maine's rural nature and town meeting format of local government essentially preclude any significant County government structure or influence. The two largest cities (Portland and Bangor) maintain local health departments (LHD) however there are no other health departments in Maine. Most public health (PH) functions are concentrated at the state level with minimal staffing and funding. The absence of LHDs and county government is further complicated by issues of uneven provider distribution, economic disparity, and a large rural population. These challenges require the Maine CDC to provide some direct services in order to ensure statewide PH services access for our most vulnerable populations. The State's capacity to perform many categorical PH

functions is extended through contracts with private health agencies; i.e. home health agencies, hospitals, rural health centers, and private physicians. Access is augmented by a developing telemedicine system statewide both in the areas of physical and mental health services. Hospitals and health centers particularly in the northern portion of the state are beginning to connect with specialists and tertiary care centers for consultation. Sunbeam Island Health Services (SIHS), a program of the Maine Sea Coast Mission offers health promotion and screening clinics via telemedicine to several of Maine's more remote islands. The Telemedicine program operates from the Sea Coast Mission ferry and is seen as an essential program to sustainable life on the isolated islands off the coast. Services vary from follow-up checks between prenatal visits to PH education. SIHS worked with the Ellsworth WIC office to become a WIC site and provides WIC services to Island women and infants.

Through Public Health Emergency Preparedness (PHEP) efforts the Maine CDC and its' public health partners continue to focus on strengthening PH functions at the local level. Establishment of regional epidemiology teams occurred through the state's PHEP activities, with the state divided into six regions that align with the Emergency Medical Services regions. Renewed discussions around Maine's PH infrastructure began during FY06 when legislation was passed to establish a system of Comprehensive Community Health Coalitions (CCHC). From this legislation a Public Health Workgroup (PHWG) was formed to design and make a recommendation on the framework for Maine's PH system. By January 2007 the PHWG submitted to the Legislature its report on required core competencies, functions and performance standards for CCHCs and the resource inventory and integration of funding sources. The report included identification of administrative units and regions for the purposes of administration, funding and the effective and efficient delivery of PH services. The Maine CDC Director was a member of the workgroup. The new agreed upon structure is described in Section IV A.

The Governor's Office of Health Policy and Finance (GOHPF) led the development of Dirigo Health legislation passed at the end of the first session of the 121st Legislature. A major component of the legislation was the creation of a Health Insurance Program that included health promotion, disease management, quality initiatives and health coverage through private insurance carriers that individuals, self-employed, and small businesses could buy into. Enrollment in the Dirigo Health Insurance Plan started January 1, 2005. Funding of the program was controversial. A very contentious issue during 2006 was a Savings Offset Payment (SOP), a fee assessed on private insurers to support the program, determined by the savings resulting from Dirigo reforms in the state's health care system. Effective July 1, 2007 enrollment was temporarily suspended for individuals and September 1, 2007 for small businesses and self employed to allow the Dirigo Health Program to look for ways to cut costs after the legislature did not approve the Governor's request for additional funds to expand enrollments. Exceptions were made for babies born to women who were already covered by Dirigo and new employees of small businesses with Dirigo contracts. L.D. 1005 was passed on June 8, 2009 repealing the SOP and establishing a health access surcharge of 2.14% on all paid claims. As of September 2007, when new enrollment was suspended, 15,123 members were enrolled in Dirigo Choice; 28% were sole proprietors, 25% small groups, and 47% were individuals. /2012/ The GOHPF was eliminated in January 2011 with the change in administration of the Executive Branch.

The future of Dirigo Health is unknown at this time. The Governor's biennial budget for FY12 and 13 calls for elimination of Fund for a Healthy Maine (FHM) funding and phasing out of insurance carrier assessments (a large portion of the health plan revenue) over time until the Patient Protection and Affordable Care Act begins in 2014. In FY11 FHM funds budgeted for Dirigo Health are approximately $4.4 million.

In July 2010, the 2010-2012 State Health Plan was issued. The focus of the plan was to expand prevention and primary care while at the same time reducing costs. The full report can be found at: http://www.maine.gov/healthreform/health-plan.shtml The Maine CDC continues to play a significant role in activities related to reducing healthcare costs. For example, through the publication of district ‘Performance Reports' districts can use these reports to improve health

outcomes. L.D. 1333 "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" was passed in May. One of the provisions in this legislation repealed the State Health Plan. //2012//

Primary Care

Maine has two primary referral centers for health care needs: Maine Medical Center (MMC) in Portland and Eastern Maine Medical Center in Bangor. In addition there are 36 acute care hospitals (30 are birth hospitals with obstetrical services); 15 critical access hospitals; 21 Federally Qualified Health Centers (FQHC) which includes one FQHC Look-a-like (Community Clinical Services in Lewiston) and 50 community health centers; five Indian Health Service funded health centers (three on Reservations, one in Presque Isle, one in Houlton); and one osteopathic medical school. In 2009 MMC began an affiliation with Tufts University School of Medicine in Boston (allopathic medical school). 20 of 36 seats are reserved for Maine students. Three schools (University of Southern Maine, University of Maine at Orono and Husson College in Bangor) offer Nurse Practitioner Programs. The University of New England offers a Physician Assistant program.

Prenatal Care

Efforts to improve maternal and infant status in Maine are complicated by our geography and population distribution. Multiple services are available locally prior to the occurrence of a normal pregnancy and continue through the postpartum period for women and through the first year for infants. However, our high-risk services are located in our three largest cities: Portland, Bangor, and Lewiston. Level III facilities are located in Portland and Bangor; a Level II facility is located in Lewiston. Women without insurance or documentation can access service through a free-care pool of providers and monies. The CSHN Program, through its Genetics Unit, manages a grant with MMC for the provision of perinatal outreach, which includes education of providers and consumers regarding issues pertinent to pregnancy outcomes.

Maine women receive routine clinical checks and pre-natal education. The Partnership for a Tobacco-Free Maine is aggressively addressing smoking cessation among pregnant women. More than three of four new Maine mothers reported that during a prenatal health care visit, their health care provider discussed how smoking during pregnancy could affect their baby. Among women who smoked in the three months before they were pregnant and had received prenatal care, 72.8% received at least some form of prenatal counseling on smoking cessation, according to 2004-2007 data from PRAMS. In 2004-2007 PRAMS, 65.1% of Maine new mothers reported they had any alcohol in the three months before becoming pregnant; 9% reported alcohol use in the last three months of pregnancy. Currently the Community Caring Collaborative in Washington County and the Portland Women's Task Force in Cumberland County focus on perinatal addiction. The Perinatal Nurse Manager maintains contact and provides consultation to both groups.

High-Risk Care

The geographic distribution of Level III facilities increases the challenge of improving the proportion of VLBW infants in Level III hospitals. To date, the only two counties in Maine that have achieved the Healthy People 2010 goal for VLBW infants born in Level III facilities are the counties that contain Maine's two Level III facilities (Penobscot and Cumberland). Mothers in Knox and Androscoggin counties have been significantly less likely than Maine mothers overall to deliver their VLBW infants in a Level III facility.(40) A small portion of the states MCH funds support the 24-hour statewide availability of perinatology and neonatology consults for providers. Great care is taken to transport high-risk pregnant mothers to the appropriate facility prior to delivery. However, in the event this is not possible, or an infant is born with unexpected complications, both Level III facilities facilitate transport via provision of a specially trained and

equipped neonatal transport team utilizing both air and ground transport. The Level II nursery in Lewiston limits its scope to pregnant women and neonates beyond 32 weeks gestation.

Pediatric Services

Pediatric services are provided by pediatric and family practice physicians as well as pediatric and family nurse practitioners and physician assistants. There are 1,007 actively licensed Certified Nurse Practitioners in Maine but the Board of Nursing is unable to report on practice location. We estimate that 95.1% of our children (0-18 years old) now have insurance. Because of this, we phased out the PHN Well Child Clinics and are encouraging the connection of children to a pediatric medical home. Title V funds focus on specialty or wrap-around services (e.g. pre-delivery genetic testing and post-delivery genetic counseling, or the services of a pediatric specialist (e.g. pediatric endocrinologist). A recent challenge to health care services for all populations insured through MaineCare has been reimbursement for services provided. The Office of MaineCare Services (OMS) (Medicaid) transitioned to a Maine Claims Management System (MeCMS) in January 2005. MeCMS was HIPAA compliant requiring more detailed billing information, however ongoing challenges with MeCMS resulted in the decision to outsource to a fiscal agent, UNISYS, via contract. /2012/ Implementation of Maine's Integrated Health Management System began in September 2010. The OMS experienced some challenges during the initial six month period while making the transition from MeCMS to the new billing and claims processing system as the two systems were in operation during this time. Identified issues are being resolved. //2012//

CSHCN Services

There are 53,122 individuals in Maine who meet the Federal Maternal and Child Health definition for children with special health care needs: "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." Title V Children with Special Health needs (CSHN) plays a critical role helping children and families navigate systems of care and access to appropriate health services.

The Maine CSHN plans, implements and evaluates public health programs for children with special health needs/chronic conditions. The CSHN Unit works to achieve six critical systems outcomes: Family/professional partnership at all levels of decision-making; Access to coordinated comprehensive care within a medical home; Access to adequate private and/or public insurance to pay for needed services; Early and continuous screening for special health needs; Organization of community services for easy use; and Youth transition to adult health care, work and independence.

Initiatives of the CSHN Program include:

The Newborn Bloodspot Program (NBSP) assures all infants can benefit from early identification and treatment to prevent or mitigate the effects of the Inborn Errors of Metabolism, (and other disorders) cognitive disabilities, serious illness, or death. The NBSP screens approximately 13,000 Maine newborns each year. Newborn screening personnel follow-up on infants with out-of-range results to ensure they receive further testing and if needed treatment and intervention.

The Newborn Hearing Program (NHP) supports early identification and timely and appropriate intervention for hearing loss. The NHP screens approximately 13,000 Maine newborns each year. Newborn hearing screening staff follow-up on the more than 300 infants who screen positive for hearing loss to ensure that they receive a diagnostic comprehensive audiological evaluation as early as possible and are enrolled in early intervention services no later than six months of age.

Using a public health approach, the Maine Birth Defects Program (MBDP) assesses the full impact of birth defects on Maine children and their families; improves access to specialty services

for families; and locates resources for emotional and economic support which includes referring the infant with a confirmed birth defect to the Department of Education (DOE)-Part C-Child Development Services (CDS). MBDP monitors trends related to prevalence of selected birth defects in Maine and educates the provider community and the general public on prevention strategies to decrease the incidence of birth defects in Maine.

The Maine Cleft Lip and Palate Program (CLPP) cares for infants, children and adolescents with cleft lip and/or palate and their families through the provision of care coordination services and clinical team care; and ensures that community-based systems exist to provide care in a coordinated and consistent manner with the proper sequencing of evaluations and treatments within the framework of the individual's overall developmental, medical and psychological needs.

The purpose of the Maine Maternal, Fetal and Infant Mortality Review Panel (MFIMR) is to strengthen community resources and enhance state and local systems and polices affecting women, infants, and families, in order to improve health outcomes in this population and prevent maternal, fetal and infant mortality and morbidity. MFIMR conducts comprehensive reviews of case summaries in order to identify factors that may lead to maternal and infant deaths; reviews statistical data for trends in maternal, fetal and infant mortality; facilitates educational efforts to increase awareness of factors contributing to maternal, fetal and infant deaths; and promotes the availability of bereavement services for families who have experienced a death of a mother, fetus or infant.

MaineCare Member Services assures that MaineCare members under the age of 21 who receive full MaineCare benefits are informed of and receive the services and assistance available to them under the MaineCare program; approximately 11,000 calls are made annually to assist families accessing medical and dental services. This partnership continues to strengthen MaineCare's role in providing and delivering health services to children.

Partners in Care Coordination (PCC) recognizes that families play a central role in caring for their child with special health care needs. PCC staff work closely with families to identify their concerns and assist them to navigate systems. PCC links families to services to optimize outcomes; promotes effective communication and collaboration between families, professionals and other partners; and, links families together so they can provide support and understanding.

The goal of the Maine Comprehensive Genetics Program (CGP) is to enhance the health and well-being of individuals and families living in Maine who have or are at risk for genetic conditions, inherited conditions and birth defects. The CGP contracts with Maine Medical Center and Eastern Maine Medical Center to provide risk assessment, laboratory/clinical diagnosis, genetic counseling, care coordination and referrals to services.

ChildLINK is the data tracking and surveillance system for the Maine CSHN Program. ChildLINK tracks the approximate 13,000 infants born in Maine in a web-based system that integrates data into a single user-friendly interface. ChildLINK links birth and death certificate data with newborn hearing screening data, audiology evaluation reports, birth defects, newborn bloodspot screening data and other CSHN Programs such as the CLPP and PCC.

The DOE, Division of Special Services reports that 32,258 (3-20) were served by special education. The DOE continues to experience a reduction in the overall number of students served by special education and reports school enrollment across Maine is declining. The DOE houses CDS (Maine's Part C Program) and reported a total of 982 children ages 0-2 were served.

Maine's Access to Dental Care

Of Maine's 46 Dental Care Analysis Areas (DCAAs) 33 were designated as Dental Health Professional Shortage Areas (DHPSAs) in 2012. Several DCAAs were assessed as no longer meeting requirements for federal designation; yet for many MaineCare members and low-income

persons in those areas, access to dental care remains difficult. In 2012, of the 46 DCAAs, 33 are designated as DHPSAs; 13 have this designation based on geographic criteria and 20 due to the proportion of low-income people in the population. Also, 19 federally qualified health centers (FQHC), two facilities, and three Native American Tribal populations are designated as DHPSAs. All of Maine's 16 counties include at least one such shortage area. Kaiser Family Foundation data shows that 15.3% of Maine's population is underserved and that 21.2% live in a DHPSA as respectively compared to 10.3% and 15.4% nationally.
http://www.statehealthfacts.org/comparemapreport.jsp?rep=114&cat=8

The number and distribution of dentists in Maine continues to present a challenge for access to care; consistent and timely data collection has also proven to be challenging. Based on data collected by the Maine Data, Research, and Vital Statistics in 2008, which counts the number of providers in active practice, there were 608 licensed active dentists practicing in Maine resulting in a statewide ratio of one dentist for every 2,493 residents. [Maine DHHS, DRVS, Maine Cooperative Health Manpower Resource Inventory, 2008] Maine's dental workforce is not distributed evenly across the state; range of 1,633 people per active dentist in Cumberland County to 4,671 in Somerset County. Nearly one-third of all Maine dentists were practicing in Cumberland County, although this county is home to 21% of Maine's population. ***/2013/ Final data from a comparable survey in 2010 has not become available, and the survey has not been completed for 2012. Data from the State Board of Dental Examiners provided to the Oral Health Program (OHP) in February 2012 indicated that of 835 dentists licensed by the State, 665 were considered "active" and had Maine addresses. Analysis conducted in December 2011 showed a range in dentist to population ratios from 1:1219 in Cumberland County to 1:4352 in Somerset County.//2013//***

According to the 2008 survey, while most active Maine dentists were currently accepting new patients (87%), only 136 dentists (26%) indicated they were accepting new MaineCare patients. 47% of active dentists in 2008 reported that they treated MaineCare patients compared to 57% in 2002. Among the providers who accepted MaineCare in 2008, 58% reported limiting the proportion of these patients in their practice. MaineCare dental reimbursement decreased significantly in the past decade relative to the costs of providing care, in spite of several targeted increases. This and issues with the state's payment system have had an impact on the extent of dentist participation in MaineCare. The reasons for this are complex, and are also related to the distribution and aging of the dental workforce. For the population as a whole, however, combining data from three surveys using data from 2003, 2007 and 2008, we estimated in 2010 that roughly 27% of Mainers had not seen a dental care professional in the past 12 months but this is regardless of age or insurance status.

Efforts to improve access to dental services in Maine have continued. The OHP continued to support and participate in the statewide Maine Dental Access Coalition, which functions as a network and broad-based stakeholder group for oral health.

The Dental Services Development and Subsidy Program authorized by the Legislature in 2001 to fund a capacity-building competitive grants program and a subsidy program for community-based dental clinics, continued to have strong support. In FY 11 eleven agencies providing services at 16 sites participated in the Subsidy Program, which helps offset the cost of providing services to uninsured adults. Capacity-building grants were continued through June 30, 2008, but in May 2009 a decision was made to direct all available funds to the Dental Subsidy Program; since the state had no capacity to support new initiatives we decided these funds would be better spent helping to sustain existing infrastructure rather to expand it. Reductions to the OHP's allocation from the FHM, the source of this program's support, reduced available funding in SFY11; a further reduction in SFY12 had a more significant impact, resulting in cutting the number of agencies to six, with services provided at 12 sites. ***/2013/ In SFY 13, with the FHM allocation cut to $300,000 from $600,000, and the split of the funds between this funding program and the School Oral Health Program (see discussion under PM #9), those six agencies will receive contracts for about 41.6% of their SFY12 amounts. The contracts are expected to***

be fully expended within six months, so this is an increasingly limited way to support access to dental care for uninsured adults.

In late 2011, a series of maps was developed to provide a visual picture of Maine's dental professional resources (dentists and dental hygienists), dental clinics, and selected preventive programs, including school-based oral health programs and community water fluoridation. They were based on the most recent data available in the fall of 2011, and will be updated as new data becomes available. A map that will locate Independent Practice Dental Hygienists and also show the service areas covered by Public Health Dental Hygienists providing school-linked services while using Public Health Supervision status is under development and will be added to this package. Download the complete Oral Health Maps series (pdf*) //2013//

In Maine's planning document, Healthy Maine 2010, a developmental objective was set to "Increase the geographic areas in Maine that have comprehensive oral health initiatives that include such components such as school-linked oral health programs, community water fluoridation, and nonprofit dental centers." By 2010, the number of those non-profit dental centers increased from the 13 identified 10 years ago to 23, assisted by state funding as well as private foundation support and expanded funding from HRSA's Bureau of Primary Health Care. An additional two clinics, one an FQHC and one a private non-profit, started up in late 2010.

The University of New England (UNE) will open a dental school in Portland, with the first class of students now expected to start in 2013. In November 2010 Maine voters approved a bond issue for $3.5 million to support the creation of a teaching clinic for a Maine-based dental school and $1.5 million to develop and/or upgrade community-based clinics that will participate with the dental school for student training. The state OHP developed the resulting Requests for Proposals and will manage the subsequent grant awards. ***/2013/ UNE received the award for the teaching clinic and construction is underway. Eight community-based organizations located throughout the state will be funded for 10 projects, for the total $1.5 million available. The grants are for construction projects or equipment purchases to better position them to serve as training sites for dental students, but also and more immediately to increase their capacity to provide dental services in underserved areas. //2013//*** In addition, Penobscot Community Health Center in Bangor sponsors general dentistry and pediatric residency programs; the Veteran's Administration Center at Togus also sponsors a general dentistry residency; and several dental clinics already host dental externs. Maine has two dental hygiene schools.

The OHP, with support from a State Oral Health Collaborative Systems Grant from MCHB, published a state oral health improvement plan in 2007. With the continuing support of a 5-year Cooperative Agreement (CA) from the US CDC, the plan is being updated with a projected publication date in 2012. The Plan and other activities of the CA, particularly around policy development and policy action planning, along with supporting water fluoridation and school-based dental sealant programs, will certainly address expanding access to dental services in Maine. ***/2013/ Maine will competitively apply for renewal of this grant in the spring of 2013. //2013//***

The OHP also works to increase access to dental care via workforce development initiatives, and has had several grants from HRSA's Bureau of Health Professions. We currently have a three-year grant (ends 8/2012) that has expanded an existing dental loan repayment program and established a new dental equipment revolving loan program, both in collaboration with the Finance Authority of Maine.

Behavioral Health Services

The merger of Maine's Departments of Behavioral and Developmental Services and Human Services in July 2004, created a new DHHS and opened a myriad of possibilities for the Maine

Title V and Office of Child and Family Services (OCFS) to unite in leadership to strengthen the systems and policies to support healthy emotional and cognitive development for all children and families. Early childhood intervention and home visiting services are shared between the Offices, with Public Health Nursing, Parent's are Teachers Too, and Alternative Response Programs aligning to offer a range of home visiting services. Programs are being integrated with other services provided to those populations for a more effective and efficient delivery of care. New opportunities that have already emerged include:

1. The strong emphasis in the Humane Systems for Early Childhood Grant on social and emotional health. The
   Children's Growth Council has an action team that specifically addresses how the state early childhood plan
   will recommend action steps to humanize and de-stigmatize our approach as a state to this issue.
2. Collaboration between Children's Behavioral Health Services (CBHS) and Title V on systems issues such as
   transition from youth to adulthood of people with special health needs and vulnerable groups such as high-
   risk youth who have disconnected from services as they transition from the pediatric to the adult system of
   care and services. In addition CBHS brought Title V into the planning for implementation of Project LAUNCH
   through the Washington County Community Caring Collaborative to promote child wellness.
3. Continued involvement of Title V leadership in a SAMHSA grant to strengthen state and local mental health
   systems as they relate to emergency preparedness.
4. Continued involvement of Title V leadership with efforts to strengthen systems of care for children affected by
   severe psychological trauma.
5. A project, led by the Maine AAP and the Maine CDC, to raise awareness and change the role of physicians in
   schools so that they become engaged as leaders in collaboration to address school health issues that relate
   to social and emotional development.
6. Integration of members of the MIPP into the OCFS, Child Death and Serious Injury Review Panel to bring a
   stronger public health approach to the panel.

The purpose of PH, as defined by the Institute of Medicine, is to foster conditions that will enable the whole population to achieve optimal health. We continue to sharpen and increase our focus on issues involving the medical and behavioral health care systems.

Despite a significant growth in the number of licensed clinicians and psychiatrists in Maine, the need continues to outstrip demand. Primary care physicians have been identified by their patients as the preferred source for behavioral health services, yet these providers often have limited training and expertise in diagnosis and management of complex behavioral health problems. Also, primary care providers struggle with referring patients to a complex, fragmented and confusing behavioral health system with a history of less than optimal communication and collaboration. In recent years, CBHS embarked on a search to explore new and innovative means of addressing the challenges. The Maine Title V Program has been a partner in this search with child and adult behavioral health since 2003. /2012/ In FY11 The Maine Children's Alliance held focus groups with several organizations involved with children's mental health and developed a "Guide to Challenges in Children's Mental Health: The Views of Maine Stakeholders". This document outlines the challenges that continue to exist (exposure to violence, lack of behavioral screening that can contribute to violence, lack of transition services) in spite of the work currently underway to address the behavioral health issues of Maine's children and families. The document

can be found at: http://www.mekids.org/am/publish/cat_index_9.shtml //2012//

A promising model that we want to put into practice in Maine is an integrated system of primary care and behavioral health through the Patient Centered Medical Home (PCMH) Improvement Project. While still relatively new, this system has been successfully implemented in other states. Although its details vary according to the unique needs and strengths of communities, the model views the primary care physician as the primary source of behavioral health care and focuses on developing a link between the child's medical home and the behavioral health care system. /2012/ The PCMH pilot is being implemented in 26 practices statewide that include four pediatric practices. //2012// See Federal Performance Measure # 3 for more detail

CBHS took steps to further address this issue through action led by the Medical Director for Behavioral Health, Dr. Elsie Freeman, who expanded the reach of this effort to include services for people of all ages; and started work with MaineCare to alter its rules to facilitate integration. At this time, there are about 25 sites around the state that are using a variety of approaches to integration, and a number are studying outcomes. Also, the Department, including Title V, continues to strongly support integration and, in particular, Ed Wagner's Care Model out of Washington State. The Humane Early Childhood Systems Plan, released by the Children's Cabinet in March 2006, strongly emphasizes the need for integration of behavioral health and socio-emotional development into an early childhood system that provides essential resources, shares common standards for quality, and respects the diversity of Maine's children and families. CBHS, in partnership with Title V and many other agencies, is implementing its Trauma-Informed System of Care Grant. The emphasis of this grant on family and youth involvement, interagency collaboration, and cultural and linguistic competence mirrors the philosophy for humane systems change in Maine Title V. A uniquely strong partnership between the Trauma-Informed System of Care Grant (Project THRIVE) and Title V has emerged.

B. Agency Capacity

Our many partnerships and collaborations expand our capacity to ensure good penetration of services in all but the most northern area of our state and a few other remote pockets where we continue to be challenged by difficult access to care. The goal of the Division of Population Health (DPH) is to promote health and prevent disease, injury and disability through a variety of cross programmatic public health interventions ranging across all three levels of prevention through broad-based community health promotion initiatives, early detection, health systems interventions, delivery of health services and the promotion of healthy public policies.

We are part of an ongoing national trend to re-evaluate the role of public health policy and programs in state systems and infrastructure. We use the five-year planning process as an opportunity to reassess our overall direction. Because we must continue to be the "safety net" and provide direct services for some of our most vulnerable residents, changes in program focus and activities must be done with great care and forethought. This is a multi-year process, requiring transitioning of resource allocations from traditional to current and emerging priorities. Continued collaboration with stakeholders and representative advisory groups is critical.

Strong relationships with organizations, in particular the University of Southern Maine (USM), Muskie School; University of Maine at Orono; and Medical Care Development are critical to our programs success. These organizations not only provide manpower but also make available critical expertise on issues important to Mainers.

Beginning in 2000 the DPH has focused increased financial and human resources to develop a strong MCH Epidemiology Team (Epi Team). The MCH Epi Team has had 3 FTE epidemiologists since 2008; one doctoral-level epidemiologist, Dr. Erika Lichter and 2 MPH epidemiologists, Cindy Mervis and Denise Yob. Combined with chronic disease funded epidemiologists there are a

total of 6 epidemiologists. During FY11, three additional support staff positions were added to the MCH and chronic disease Epi Team. The MCH Epi Team is financed through State Systems Development Initiative (SSDI), State MCHBG match funds and several federal categorical grants.

During the past ten years, the DPH has significantly expanded its capacity specific to epidemiology. An area for growth is evaluation. Staff within the DPH has the capacity to conduct simple process evaluation. We contract with evaluators from the University of Maine, University of New England, and consulting firms such as Hornby Zeller Associates for more complex evaluation plans and specific time limited projects. A DPH priority is to develop capacity within the Title V programs related to evaluation, which will strengthen Title V resources available to the emerging public health districts.

Title V funded programs serving pregnant women, mothers, infants and children are detailed on the attached Table 1.

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The State Title V Agency in Maine is within the Department of Health and Human Services (DHHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the DHHS's Maine Center for Disease Control and Prevention (Maine CDC). Programs that focus primarily on the Maternal and Child Health (MCH) population are found in the Division of Population Health (DPH). The day-to-day management of the MCH Block Grant is carried out in the DPH, with Valerie Ricker designated as the manager with ultimate responsibility for administration of the MCH Block Grant.

Brenda Harvey, Commissioner of Maine's DHHS, reports directly to Governor John E. Baldacci. Dora Anne Mills, M.D., M.P.H. serves as Director of the Maine CDC and is the State Health Officer. /2012/ Mary Mayhew was appointed Commissioner of DHHS in February, 2011 by our new Governor, Paul R. LePage. Sheila Pinette, D.O. was appointed Director of the Maine CDC in March, 2011. Dr. Pinette has a diverse medical background. She practiced as a Physician Assistant, as an intensivist cared for high-risk moms, and ran her own internal medicine practice prior to her appointment as the State Health Officer. //2012// ***/2013/ Valerie Ricker, M.S.N., M.S. is Assistant Director of the DPH which houses direct service programs and population-based prevention and health promotion services. Ms. Ricker reports to Debra Wigand, MEd, CHES, the Director of the Maine CDC, DPH. //2013//*** Stephen Meister, M.D., MHSA, is the MCH Medical Director. ***/2013/ Dr. Meister left his position in July 2011; In June 2012 Christopher Pezzullo, D.O. was hired as the Medical Director for the DPH. //2013//*** We have three MCH epidemiologists, Erika Lichter, ScD., Cindy Mervis, MPH and Denise Yob, MPH. The DPH continues to support a women's health coordinator position in an effort to focus attention on women's health in a more comprehensive manner. ***/2013/ As part of a Maine CDC re-organization the Women's Health Program was relocated to the Office of Health Equity. We continue to remain connected with the program on women's issues. //2013//***

A recent partner, Maine's tobacco prevention program, known as the Partnership for a Tobacco-Free Maine (PTM) supports various MCH efforts through the Fund for a Healthy Maine (FHM). This fund was established in 1999 by the Legislature to receive and disburse tobacco settlement payments. Annually the largest proportion of FHM funds are directed toward tobacco prevention efforts. PTM routinely collaborates with the Teen and Young Adult Health, Women, Infant and Children, Public Health Nursing, Community Health Nursing and Maine Families Home Visiting Programs on tobacco-related issues. Other MCH related areas receiving FHM funds include providing support for childcare subsidies, school-based health centers, and family planning. PTM is located in the Maine CDC, DPH. /2012/ The Governor's biennial budget recommends substantial reductions of FHM funding for home visiting and oral health. Supporters have advocated for restoration of some or all of the funding. //2012// ***/2013/ The Governor's FY13***

budget called for a $2.6 million cut for home visiting, $401,000 for family planning and School-Based Health Centers to be cut by two thirds. In early June 2012 the Legislature passed a budget that upheld the Governor's elimination of FHM funding for home visiting and family planning services and eliminated one third of the FHM funds for tobacco prevention. Funding for School-Based Health Centers was not eliminated. //2013//

On September 17, 2005 phase two of the DHHS reorganization became law. Contained in the law were several components which impacted the Title V Program. First was a change in name of the Bureau of Health to the Maine CDC. Second was the movement of the Early Childhood Initiative (ECI) and the Maine Families Home Visitation Program (MFHV) to a new Early Childhood Division within the Office of Child and Family Services (OCFS), the state child welfare agency. The change in physical location, as well as, reporting configuration became effective January 2008. The ECI coordinator continues to meet regularly with the Title V Director on the ECI and home visiting activities. ***/2013/ During the Legislative session the DHHS proposed a re-organization to reduce the number of offices within the Department by merging several offices and re-structuring others; the Legislature approved the re-organization. The Early Childhood Initiative and Maine Families Home Visiting will move back to the Maine CDC within the Office of Health Equity. //2013//***

In May 2005 the Maine CDC started a strategic planning process based upon knowledge gained through The Strategy-Focused Organization by Robert S. Kaplan and David P. Norton. The strategic planning process resulted in relocation of several programs within the Maine CDC. The Maine Injury Prevention and Teen and Young Adult Health Programs are now located within the DPH.

A hiring freeze continues to delay filling federally and state funded positions. /2012/ Four of the vacant public health nursing positions received approval from the DHHS Commissioner but have not received approval from the Department of Administrative and Financial Services for exemptions to the freeze for key positions. //2012// Maine's remote location and salaries that are non-competitive with neighboring state's urban areas continue to pose recruiting challenges for the Department. Ongoing shortfalls in the state budget pose difficulty in hiring into state funded positions. Starting in March 2009 however, other on-going vacancies prevented programs from carrying out all planned FY activities. /2012/ This has continued throughout FY12. //2012// ***/2013/ Retirement incentives available through August 2011 resulted in numerous frozen positions, four of which are MCHBG funded. Since January 2012 the Maine CDC has received approval to fill most non-frozen positions. //2013//***

The MCH leadership has clinical training and expertise. They maintain membership with their respective professional organizations i.e. Maine Nurse Practitioner Association, Maine Chapter of American Academy of Pediatrics, and North East Rural Pediatric Association ensuring an ongoing relationship with primary care providers. Several MCH personnel are also involved in statewide and national initiatives that involve primary care.

In 2007 Dr. Dora Anne Mills, Maine CDC Director approved the reorganization of the DFH. The reorganization groups the DFH programs into four sections; children with special health needs, public health nursing, women infants and children, and population health and prevention with the leader of each section reporting to the DFH Director. ***/2013/ In Fall 2011, the Maine CDC underwent a re-organization to create greater visibility for the newly emerging Office of Local Public Health by making it a Division rather than an Office. DHHS also directed the Maine CDC to maintain the same number of Divisions therefore the Divisions of Family Health and Chronic Disease were merged into a new Division of Population Health. This change resulted in the WIC and Public Health Nursing Programs relocating to the new Division of Local Public Health and the Women's Health Program to the Office of Health Equity. The CSHN, Injury Prevention and Teen and Young Adult Health Programs remain in the merged Division of Population Health. //2013//***

Organizational charts indicating positions and/or programs supported with Title V funds are attached. /2012/ With the change in administration during the past SFY, the DHHS continues to transition and a revised organizational chart is pending Commissioner approval. As of this report a graphic version was not available. //2012// ***/2013/ As of this report a revised DHHS organizational chart is pending Commissioner approval. //2013//***

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The majority of the MCH Title V program staff are centrally located in Augusta, our State Capital. Staff classifications include: clerical support, health planners, planning and research assistants, health educators, program managers, accountants, and Medical Director and administrative senior managers. Title V also funds 24.5 positions outside the Division of Population Health (DPH): one person in Data, Research and Vital Statistics; two in the Health and Environmental Testing Laboratory (support lead testing, sexually transmitted disease testing, etc.); two in the Office of Health Equity, Project LAUNCH and the Women's Health Coordinator; 17.5 in the Division of Local Public Health (17 in Public Health Nursing and .50 FTE in WIC) and two in the Department of Education (work with schools to develop and utilize comprehensive health education curricula). All of these positions contribute to the achievement of MCH priorities. Parents of children with special health needs form the leadership and body of the Family Advisory Council (FAC). Youth with special health needs are the body of the Youth Advisory Council (YAC) with staffing provided by the youth coordinator. The recent opportunity to add a 5th delegate to Maine's Association of Maternal and Child Health Programs (AMCHP) members initiated conversations to identify the most appropriate person to represent Maine families. A young adult with special health needs and a parent of a child with special health needs were hired through the State Implementation Grant. Each of these positions is a liaison to the larger FAC and YAC. /2012/ The parent, Anna Cyr, is the AMCHP delegate. Two parents have been hired through the HRSA/MCHB/Universal Newborn Hearing Program to conduct follow-up for the Newborn Hearing Screening Program for infants identified with a refer at hospital discharge. //2012// The young adult coordinates youth-focused activities and reviews materials, from a youth perspective. /2012/ During FY10 our youth coordinator assumed the role of youth coordinator for the new National Health Care Transition Center reducing her time to approximately 10-15% on youth activities in Maine. //2012// ***/2013/ In FY11 the youth coordinator took a fulltime position with the National Health Care Transition Center providing technical assistance to states, facilitating monthly webinars on transition. The position remains vacant. //2013//***

Data, Research and Vital Statistics (DRVS) provide data for this grant application and meet with the Epi Team and DPH managers for specific data needs. Our increased epidemiology capacity is leading to increased cross divisional work between the DPH and DRVS on MCH priorities. The Department of Education (DOE) works closely with the Manager of the Coordinated School Health Program to develop and use comprehensive health education curricula that include sexual health. We believe that by facilitating the development of individuals who understand their bodies and take ownership of their health care we have lowered our teen pregnancy rates, increased abstinence and decreased the incidence of sexually transmitted diseases.

Through the State Systems Development Initiative and other categorical funds we have increased our epidemiology capacity. Our epidemiologists have worked closely with the DOE and other public health partners to develop a survey with multiple health indicators that will help us monitor Maine's children's health status and develop a long-term surveillance system within the Maine CDC. The Maine Integrated Youth Health Survey (MIYHS) was designed to consolidate the number of surveys that schools were asked to participate in and optimize school acceptance of these surveys. The first MIYHS was administered in 2009 and data became available in Spring 2010.

During the early 1990's support for many state funded positions was assumed by the MCHBG. A

state budget deficit resulted in positions being cut if other funding sources could not be identified. Converting Public Health Nursing (PHN), Teen and Young Adult Health, Maine Injury Prevention, CSHN and Oral Health positions to federal funds facilitated maintenance of staff providing services to the Title V population. In FY02, staff salaries exceeded available federal funds; a short-term alleviation included salary savings through vacancies and medical leave, freezing vacant lines and extensive reductions in purchased supplies and materials. A medium-term remediation involved generation of revenue to support positions to be accomplished through fee-for-service and targeted case management. Once again in March 2010 salaries exceeded revenue resulting in lines being frozen. Currently there are 11 vacancies within the programs serving the MCH population. The vacancies are within the Children with Special Health Needs, Public Health Nursing, Population Health and Prevention, and Oral Health Programs. Filling clinical positions such as PHN are particularly difficult due to low salary differences between state government and the private sector. ***/2013/ Currently there are seven vacant PHN field nurse positions with two positions frozen until Fall 2013 due to retirement incentives. //2013//***

Title V partially supports 54 Public Health Nurses (4 supervisors and 50 field nurses) who are based statewide in 13 regional satellite offices. These nurses provide direct services via home visits, school health, immunizations, specialty clinics, and participate in our program planning/evaluation. The Title V Program also has an agreement with the University of Southern Maine's, Muskie School of Public Service for assistance with facilitation, performance measurement, and quality improvement activities.

Senior level management include: Valerie J. Ricker, DPH, which has administrative responsibility for Title V. Ms. Ricker has 30 years of experience in MCH, 15 years with the Maine CDC as Title V Director. She has a BSN and MSN in Nursing and MS in MCH, focusing on Public Health. ***/2013/ Valerie Ricker continues to have administrative responsibility for Title V and is now the Assistant Director of the Division of Population Health. //2013//*** Dr. Stephen Meister, MCH Medical Director, is a graduate of Tufts University School of Medicine. He served his internship and residency at The Children's Hospital of New York at Columbia Presbyterian Medical Center. He later was awarded a Masters in Health Services Administration from The George Washington University School of Medicine and Health Sciences. During his active duty in the US Navy, Dr. Meister served as Division Head of the Pediatric Acute Care Clinic at the Naval Medical Center in San Diego. In 2003 and again in 2007, Dr. Meister received recognition by the American Academy of Pediatrics with a Special Achievement Award for his work with the Pediatric Rapid Evaluation Program, a program developed to evaluate the medical and mental health needs of children entering foster care in Maine. Dr. Meister has been in practice as a general pediatrician for 23 years. He is the author of presentations on the assessment of stress/trauma in children and the medical needs of foster children. ***/2013/ Dr. Meister left the Maine CDC in July of 2012 to become the Medical Director of the Edmund N. Ervin Pediatric Center at Maine General Medical Center. He continues to remain connected through his work with the Child Death and Serious Injury Review Panel and other MCH related projects. With the development of the Division of Population Health (DPH) the MCH Medical Director position was renamed to the Division of Population Health Medical Director. Dr. Christopher Pezzullo was hired June 18, 2012 as the new DPH Medical Director. Dr. Pezzullo received his Doctor of Osteopathy degree from the University of New England and completed a residency in pediatrics at Maine Medical Center. He has 17 years in clinical medicine including positions as Chief Medical Officer of University Health Care and Pediatric Chair at the University of New England. //2013//*** Toni Wall is the Director of the CSHN Program and has been in this position for 12 years. She has 24 years experience working in Maine CDC Programs. Her past experience has prepared her to influence and manage the program. Ms. Wall holds a Masters in Public Administration with a concentration in Health Care Administration. Jan Morrissette has been the Director of Public Health Nursing for 6 years. She has been with PHN for 25 years starting as a field nurse. She holds BSN and MSN degrees and is a Robert Wood Johnson Executive Nurse Fellow. ***/2013/ Ms. Morrissette retired in November 2011; the Division of Local Public Health is recruiting for the position. //2013//*** Lisa B. Hodgkins received her B.A in Psychology and M.Ed in Counseling from the University of

Maine at Orono. She has worked in both the private and public sectors and has spent twenty years of her career in state government, most recently as the Director of the Women, Infants and Children's Nutrition Program. Her years in the private non-profit sector were in the areas of children's behavioral health and school based health care. Nancy Birkhimer is the Section Leader for Population Health and Prevention within the DFH at the Maine CDC. This section includes the Maine Injury Prevention Program, Women's Health, Teen and Young Adult Health, the Safe Families Partnership, and the state's MCH Epidemiology Unit. Previously, Ms. Birkhimer served as the Director of the Teen and Young Adult Health Program and the State Adolescent Health Coordinator for ten years. Ms Birkhimer has an MPH in Epidemiology and International Health from Boston University. /2012/ Ms. Birkhimer accepted a position as Director of the Office of Performance Improvement, also within the Maine CDC, in December 2010. The Population Health and Prevention Section Leader position remains vacant due to a hiring freeze. //2012//

Dr. Erika Lichter, the MCH Epidemiology Team leader, has a ScD in Public Health with a major in MCH and minors in Biostatistics and Epidemiology from the Harvard School of Public Health and a master's degree in Developmental Psychology from the University of Arizona. Cindy Mervis, MPH brings 14 years of experience as an Epidemiologist, many of which were with the federal CDC. Approximately 50% of her time is focused on MCH related projects. Denise Yob, MPH brings experience with needs assessments within a statewide network of community-based family support centers and Early Head Start sites. She also assisted in analysis for the National Evaluation of Fetal and Infant Mortality Review Programs. Her focus is on MCH activities.

Biographical sketches are on file in the Maine CDCs Division of Population Health and will be made available for review on request.

E. State Agency Coordination

The Maine CDC/Division of Population Health (DPH) has several methods for establishing working relationships/collaborations with other entities. (Table 2 attached) We seek out and engage key stakeholders that provide services and develop policies for our shared populations. We have a reputation of working well in a collaborative style and therefore others approach us when they determine that we are stakeholders in their initiatives. Finally, we convene planning groups and ask for consensus on group membership and involvement. Maine Title V has been responsible for: Creating a Children's Growth Council of varied state, community, and family representatives; Developing comprehensive grant proposals for early childhood systems, women's health, integrated services for CSHN, and an implementation grant for traumatic brain injury; Sharing resources and ideas for survey development; Providing leadership in the development of an integrated youth health survey to reduce the number of survey requests made to schools; Connecting the Department of Labor with Child Care Resource Development Centers to meet MCH population needs for child care when seeking training or employment; Leading ad hoc groups to study and report on the prevention of prematurity and, on early childhood as an economic development issue; Engaging, with the MCH Medical Director's involvement, the Maine Chapter of AAP participation in a family centered survey dealing with child care in the workplace; Promoting interagency training, including cultural and linguistic competence, oral health, and assets; Supporting the Maine Chapter of AAP in developing a website for their organization; Coordinating a group of state and non-governmental partners to take a public health approach to domestic violence and sexual assault through the Maine Safe Families Partnership; Implementing a Maternal, Fetal, and Infant Mortality Review Panel; Engaging with MaineCare Member Services on improving EPSDT services for children; Providing leadership, through the efforts of our MCH Medical Director, in engaging the participation of statewide physician groups in a patient centered medical home pilot. This pilot is one of the few, nationally, which has included pediatric practices from the inception of the program; and Engaging with the Office of MaineCare Services on a Children's Health Insurance Program Reauthorization Act, Improving Health Outcomes for Children grant to enhance medical practice capacity for child health quality improvement.

The Maine CDC DPH continues to develop a relationship with Maine's primary care organization Maine Primary Care Association (MPCA). This organization has many competing priorities; the patient population served by community and rural health centers covers the lifespan, thus MPCA involvement in MCH issues is limited. Over the last three years MPCA led a campaign to increase funding for childhood immunizations allowing Maine to return to being a universal vaccine state. In addition MPCA has partnered with the DPH in developing learning collaboratives related to women's mental and behavioral health (depression and substance abuse).

An attachment is included in this section. IIIE - State Agency Coordination

F. Health Systems Capacity Indicators

#01. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children less than
five years of age.

The data for this indicator are derived from Maine's Inpatient Hospital Discharge Database and population estimates from the US Bureau of the Census. 2010 hospitalization data were not available at the time this report was written. Based on the most recent data available, the rate of hospitalization for children under age 5 was 19.4 per 10,000 in 2009. This rate is slightly lower than the 2008 rate, but since 2004, the rate of asthma hospitalizations among this population has remained relatively stable.

Data on the prevalence of childhood asthma were collected as part of the Maine Integrated Youth Health Survey, a school-based survey of children in grades 5-12 and parents of kindergarten and 3rd graders administered in Spring 2011. Among middle schools students, 22.6% reported that they had ever been told they had asthma. Of these students, 49% still have asthma. Similarly, 25.8% of high school students reported that they have ever been diagnosed with asthma and 43.8% of these students still have asthma. Of students in 5th and 6th grade, 17.5% had been diagnosed with asthma and 12.9% of parents of kindergarteners and 3rd graders reported that their child had been diagnosed with asthma.

In the state asthma plan, children are identified as a population that is disparately affected by asthma and there are several objectives related to improving asthma management among children. Through federal CDC funds, the Maine Asthma Program (MAP) has been working to improve asthma management among children with the goal of reducing hospitalizations; efforts include working with physicians in schools to increase the number of children with asthma management plans, providing community grants to increase asthma management education, providing peak flow meters to children, and training school nurses on asthma management plans. Other strategies include enhancing Maine's asthma surveillance system, and building and evaluating partnerships.

In 2010, MAP funded a Learning Collaborative developed by the Maine Primary Care Association that allowed 12 pediatric practices to receive education of the NHLBI guidelines for asthma care in adults and children. A Grand Rounds was presented at Maine Medical Center that highlighted the work of the Learning Collaborative.
One of the subcommittees of the Maine Asthma Council is the Homes Workgroup. This group conducted trainings in Spring 2011 in Machias and Waterville for landlords and property managers on healthy home concerns (e.g., mold, lead, radon, indoor air quality and asthma). As of July 2011, all of the apartments managed by the Portland Housing Authority, Portland's largest landlord, became smoke-free.

#02. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic
screen.

Data for this indicator are provided by Maine's Office of MaineCare Services (OMS). In FY11, 84.1% of MaineCare enrollees under 1 year of age received at least 1 initial periodic screen. However, due to claims bundling by Rural Health Centers, FQHCs, and ambulatory hospital based clinics, this estimate may not be accurate because there is no way to tell if a service received at one of these settings is a periodic screening for infants. All we can do is count whether or not the infant had a claim. This number is higher than FY10, but lower than previous years. A new Medicaid data system went into effect in September 2010. Analysts at OMS have noticed a drop in claims in all reports since the new system went into effect. They are not sure whether this is due to implementation of the new claims management system or because several large providers were subsumed by hospital systems and may therefore be billing differently.

Overall management of the EPSDT Program resides within the OMS. In 2007, the informing and referral assistance component was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the Division of Family Health, home of Maine's Title V agency and is currently managed by the CSHN Program. Movement of this component into the CSHN Program has provided Maine's Title V program with the opportunity to influence infant access to periodic screening as well as the content of information provided to MaineCare subscribers.

In Spring 2010, Maine, in collaboration with Vermont was awarded one of 10 grants from the U.S. DHHS to improve the quality of health care delivered to children, with a focus on children enrolled in Medicaid and SCHIP. Maine and Vermont are sharing $11.3 million in funding from the CMS over five years. With this grant, MaineCare, the Maine CDC and the Office of Vermont Health Access are working with their state universities to develop and test several initiatives to determine whether or not they are effective in improving children's health.

As part of Maine's SSDI application, Maine's Title V agency has started formalizing a partnership with the OMS. Through this partnership, which will lead to the use of linked MaineCare and birth certificate data, Title V will work towards increasing the number of infants who receive early screening and address the measurement of this indicator.

#03. The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one
year who received at least one periodic screen.

Data for this indicator are provided by Maine's OMS. In FY10, 50.9% of SCHIP enrollees under 1 year of age received at least one initial periodic screen (14 out of 26 enrollees). The small number of infants enrolled in SCHIP may cause this estimate to vary substantially over time.

Prior to the development of SCHIP, Maine's Medicaid Program covered infants up to 185% FPL. With the addition of the SCHIP Program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, FQHCs, and ambulatory hospital based clinics are permitted to bundle their MaineCare claims. With claims bundling, the MaineCare agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. As a result, this indicator may be underreported.

As mentioned under HSCI # 02, in November 2007, the informing and referral assistance component of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to Maine's Title V agency. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population. Maine's State System Development Initiative will also help monitor infant receipt of periodic screens by allowing Maine's Title V agency to access linked birth certificate and Medicaid data.

Maine's new Child Health Insurance Program Reauthorization Act (CHIPRA) grant should help improve the quality of care received by children enrolled in SCHIP, including receipt of early and

periodic screens (see HSCI #2 for more information on this initiative).

#04. The percent of women (15 through 44) with a live birth during the reporting year whose observed to
expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Data on prenatal care are derived from birth certificates provided by Maine's Data, Research and Vital Statistics. In Maine, 86.1% of women with a live birth in 2010 received at least adequate pre-natal care (defined as 80% on the Kotelchuck Index). Since 2003, Maine's estimate on this indicator has remained fairly stable with adequate prenatal care estimates ranging from 83.8%-87.5%.

Maine's Title V Program is working on improving the adequacy of prenatal care in the State through ongoing monitoring efforts. Maine has had the PRAMS in place since its inception. These data provide valuable information on women's pre and post pregnancy behaviors. Maine also examines and publishes data on pre-natal care and birth outcomes using birth certificate data. Through an SSDI grant, Title V will begin working with MaineCare to link birth certificate and MaineCare data to examine birth outcomes in relation to pre-natal care. By examining these data and disseminating the results, we hope to increase the % of women in Maine receiving adequate prenatal care. Title V also works very closely with WIC to encourage women enrolled in WIC to obtain prenatal care.

Efforts to improve prenatal care include 1) Maine Families Home Visiting Program, which now has a contracting performance measure related to the % of prenatal enrollments into the home visiting program; 2) The Perinatal Substance Abuse Collaborative Project, a vibrant multi-disciplinary group that addresses systems issues such as ensuring a non-punitive approach to the new neonatal drug exposure reporting law and establishing standards for breastfeeding among women taking methadone; 3) The Maine Early Childhood Plan has several recommendations related to prenatal care, and 4) Maine's MFIMR Panel.

Maine received a SAMHSA grant to address unmet child health needs between the ages of prenatal to eight years of age in Washington County. This Project LAUNCH demonstration is working with pregnant women who are at risk for a preterm birth and/or a prolonged hospitalization due to neonatal abstinence syndrome. One initiative is a pre-delivery visit by the mother, her support person and one of her service providers to the Eastern Maine Medical Center (EMMC) neonatal intensive care unit. This visit prepares the mother for the potential needs of her baby in the postpartum period as well as familiarizes her with EMMC staff, starts hospital discharge planning including follow up visits. This is done in order to facilitate positive bonding between the mother, her baby and her immediate support system.

Tables with district-level public health data were produced in 2008 and updated in 2010.
http://www.maine.gov/dhhs/boh/health_indicator_comparison.htm
These tables include data on the % of women receiving prenatal care in the 1st trimester by district. By raising awareness of key MCH-related health issues in individual districts across the state, such as adequate prenatal care, Maine's Title V Program hopes to work more closely with communities to improve this indicator. In addition, early and adequate prenatal care was selected as an objective for Healthy Maine 2020. Maine exceeds the Health People 2020 target for this measure (77.6%); the Healthy Maine 2020 target is 90%.

#05. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the
State.

Maine has put a great deal of energy into expanding eligibility for MaineCare and simplifying the enrollment process. MaineCare incorporates the Child Health Insurance Program (CHIP). It covers pregnant women and children birth through 18 up to 200% of the federal poverty level.

The number of claims received from MaineCare for FY11 is lower than in previous years. This may be due to a change in the MaineCare data system that went into effect in September 2010. Analysts at OMS noticed a drop in claims in all reports for FY10. They are not sure whether this is due to implementation of the new claims management system or because several large providers were subsumed by hospital systems and may therefore be billing differently.

It is important to note that the data presented for the non-MaineCare population include those who are uninsured, as well as those who have private insurance. The percent of low birth weight babies among MaineCare enrolled infants is similar to those not enrolled in MaineCare. However, those insured through MaineCare were less likely to start prenatal care in the 1st trimester and have adequate prenatal care, as defined by the Kotelchuck Index.

Collaborations with MaineCare on understanding the differences within HSCI #5 have allowed us to understand the complexity of MaineCare, how, for example, the MaineCare population includes a heterogeneous mix of recipients who qualify through multiple categories; and how the way that MaineCare defines eligibility (one month versus 11 month enrollment in a given year) significantly affects the indicators. At the same time, by working together, MaineCare has learned from Title V that MaineCare enrollment itself does not translate into full access to a medical home for a recipient. Through Maine's SSDI grant, we plan on increasing collaborations between Title V and MaineCare to better understand these differences and work towards improving this indicator.

#06. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1),
children, and pregnant women.

In Maine, SCHIP is combined with MaineCare. Together, these programs cover infants, children and pregnant women up to 200% of the federal poverty level. Prior to the development of SCHIP, Maine's Medicaid Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. In 1999, MaineCare blended SCHIP with Title XIX.

#07A. The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

According to Maine's Medicaid office located within the OMS, 85.0% of MaineCare eligible children received a service paid for by the MaineCare Program in FY11. This is about the same as FY10, but slightly lower than the percentages reported for FY06-FY09. Between 2001-2006, the percent of MaineCare eligible children who have received a service from MaineCare steadily increased indicating that more children who are eligible for services from MaineCare were receiving them, but has leveled off in recent years and FY10 and FY11 represent a decline in the percent served. As mentioned above, this may be due to a change in the MaineCare data system that went into effect in September 2010. Analysts at OMS have noticed a drop in claims in all reports for FY10. They are not sure whether this is due to implementation of the new claims management system or because several large providers were subsumed by hospital systems and may therefore be billing differently.

As mentioned under HSCI # 02, in November 2007, the informing and referral support component of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the Division of Family Health, home of Maine's Title V agency. This component of the EPSDT Program is currently managed by Maine's CSHN Program. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population.

Maine's OMS has initiated a monthly meeting of stakeholders to develop goals for Maine's EPSDT program, which will include increasing the number of children who receive EPSDT

services. This group was convened in September 2008 and continues to meet on a regular basis. One of the goals of this group is to develop strategies to help MaineCare in attaining the 80% benchmark participation for Maine children and youth as required by federal CMS.

The CHIPRA grant received by Maine and Vermont in 2010 is designed to increase the quality of care among children enrolled in MaineCare. This project should help increase use of medical services among Maine children enrolled in Medicaid (see HSCI #2 for a full description).

#07B. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services
during the year.

The OMS reported that 56.6% of EPSDT eligible children aged 6-9 received any dental services within FY11. This indicator has remained stable over the past few years.

The Maine Oral Health Program continued to fund and coordinate the school-based/school-linked School Oral Health Program (SOHP). The number of participating schools has decreased due to school redistricting and school closures. Children in many schools participate in a weekly fluoride mouthrinse program, and in about half of all participating schools, 2nd graders may receive dental sealants at school. School eligibility for the SOHP is determined by a formula that includes the proportion of students eligible for the Free and Reduced Lunch Program and MaineCare as well as the proportions of the community receiving fluoridated public water and whose family income is at the FPL. In this way, the SOHP is directed toward those communities and schools where children are more likely to have problems with accessing dental services, since socio-economic status is directly related to the ability to obtain dental care. Local SOHP directors work to assure that children who may be eligible for MaineCare do enroll; they also often work within their communities to find dental care for children who do not have a regular source for care. Funding constraints have resulted in closer scrutiny of the eligibility criteria and compliance with program requirements.

As mentioned under HSCI # 02, in November 2007, the informing and referral assistance components of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to Maine's Title V agency. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population regarding EPSDT eligible infants and dental services.

Maine's OMS has initiated a monthly meeting of stakeholders to develop goals for Maine's EPSDT program, which will include increasing the number of children who receive EPSDT services. This group was convened in September 2008 and continues to meet on a regular basis. A representative from Maine's OHP is a member of this group.

The CHIPRA grant received by Maine and Vermont in 2010 is designed to increase the quality of care among children enrolled in MaineCare. This project should help increase use of dental services among Maine children enrolled in Medicaid (see HSCI #2 for a full description).

#08. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State
Children with Special Health Care Needs Program.

This program pays for specialty medical care that includes in/out patient care, medications, durable medical equipment, specialists, and other medical services that are deemed medically necessary. Based on data from Maine's CSHN Program, less than 1% of Maine's CSHN participants receive SSI. This is due to the CSHN Program no longer serving (as of July 1, 2005) those clients who receive all of their services through MaineCare. Since the SSI population automatically receives MaineCare this population has been reduced. As of December 2011 the Social Security Administration reported that 3,433 children under the age of 16 were receiving

SSI.

#09A. The ability of States to assure that the Maternal and Child Health program and Title V agency have access
to policy and program relevant information and data.

Maine's capacity to analyze existing data sources has increased steadily over time. The Maine CDC's Division of Population Health has a cooperative agreement with the University of Southern Maine's Department of Applied Medical Sciences to provide epidemiologic support to programs within this division. Three new positions were added to the cooperative agreement during SFY11, bringing the total number of staff to nine. Three epidemiologists, one doctorate level and two masters level, are focused on MCH, and two research analysts and a research assistant each spend about half their time working on MCH projects. Through this increased capacity, Maine will be able to analyze and disseminate MCH-related data in a more timely and efficient manner for the Title V Block Grant, as well as for stakeholders and the general public.

Maine's SSDI project has been instrumental in increasing Maine's epidemiologic capacity to have access to policy and program relevant information and data. The SSDI initiative also helped Maine's Title V Program complete the comprehensive strengths and needs assessment for the 2010 Block Grant. In December 2006, Maine's Title V received continued SSDI funding. Through this grant, the Title V Program increased its data capacity by: (1) linking WIC and birth certificate data and birth certificate data, (2) enhancing the birth defects surveillance system, (3) developing a database for a new MFIMR Panel, and (4) supporting the development and sustainability of school health surveys.

In addition, funding from the SSDI has allowed us to explore our existing data sources to inform program policies and activities. For example, we have conducted in-depth analyses of Maine's linked birth-infant death database to examine in more detail the demographic and systems-level characteristics associated with infant mortality in the state. These analyses will inform the work of Maine's new MFIMR Panel. In addition, we have built a relationship with the OMS to access MaineCare data for key MCH indicators. We are also working with the University of Maine to enhance the usability of Maine's ChildLINK system, which includes infant birth and death data, newborn hearing, newborn screening, and birth defects. This past year, we also started examining linked data systems in other states to build Maine's data linkage capacity.

In 2009, Maine administered the first Maine Integrated Youth Health Survey (MIYHS). This ambitious survey includes questions from the Youth Risk Behavior Survey (YRBS), Maine's Youth Drug and Alcohol Use Survey, as well as other questions added by programs within the Maine CDC, including many MCH-related programs. High school, middle school, and elementary school versions were created and distributed. Many of the questions on these surveys will inform MCH programs. Data on many items will be available at the local level, which will help community-based MCH efforts. The survey was successfully administered again in 2011 and planning for 2013 is underway.

#09B. The ability of States to determine the percent of adolescents in grades 9 through 12 who report using
tobacco products in the past month.

Maine has several data systems in place that allow us to monitor tobacco use among youth in grades 9-12. Between 1995-2007, Maine administered the YRBS to middle school and high school students biennially. The YRBS is a statewide representative sample of youth and includes several questions on tobacco use in the past month and during the lifetime. Starting in 2002, in alternate years, all high schools and middle schools in Maine were invited to participate in the Maine Youth Drug and Alcohol Use Survey (MYDAUS)/Youth Tobacco Survey (YTS). This survey included detailed questions about substance use, including tobacco, within the past month and during the lifetime. Data for both the YRBS and MYDAUS/YTS are available online. Schools

that participated in the MYDAUS/YTS are able to access school-level data online as well.

In Spring 2009, Maine administered the MIYHS. This survey includes question from the YRBS, MYDAUS, as well as other questions, including many on tobacco use. High school, middle school, and elementary school versions were created and distributed. The high school survey includes several questions on tobacco use within the past 30 days, including the use of cigarettes, cigars, and chewing tobacco. The survey achieved over a 60% response rate and the data became available in Spring 2010. One of the modules of the MIYHS is Maine's YRBS. The 2011 MIYHS was administered during Spring of 2011 and data became available in Spring 2012. The response rate for all levels of the survey (k/3, 5th/6th grade, 7th-12th grades) achieved 60%, which was especially significant for the k/3 survey, which relies on parent report.

Maine has seen dramatic drops in adolescent tobacco use in recent years, showing a 60% decrease over 8 years. These drops can be attributed to a comprehensive approach that includes: (1) Maine adequately funding tobacco control and prevention, one of only six states to meet the CDC's minimum funding recommendations, (2) restricting youth access to tobacco products, through enforcement of laws and tobacco-free schools policies, (3) smoke-free environments, including restaurants and bars, and (4) high tobacco taxes.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Maine is unique for several reasons. Geographically, Maine's land area is the size of the other five New England states combined, is divided into 16 counties, has three large cities, Portland, Lewiston-Auburn and Bangor and has a population of 1.32 million people, more than 1/3 of whom live in the two southern most counties of the state. (See Section III A for more detail.) Maine has a long history of local civic engagement with an independent, can-do spirit that fosters cooperation regardless of political beliefs. Towns continue to be the core of Maine's governmental structure in which roughly 344 of the 432 towns and cities maintain the direct democracy, town meeting format of government. County government, on the other hand, is weak.

Maine's state bureaucracy remained relatively small and underdeveloped until the 1970's and 1980's when many federal responsibilities were transferred to states, including Title V. In a widely published 1983 report to the National Governors' Association, America's Children: Powerless and in Need of Friends, Maine's DHHS provided a compelling argument for why the unmet needs of our nation's children require governmental and societal support. Maine's public health (PH) system, including MCH, was built upon this structure. Most PH functions are concentrated at the state level. While the two largest cities (Portland and Bangor) have local PH departments, the state does not have any county health departments. The Maine CDC's PHNs, PH educators, health engineers, district and tribal liaisons, and restaurant inspectors provide local Maine CDC PH presence within eight District PH Units located throughout the state (see below). The State's capacity to perform many categorical PH functions is extended through contracts with private health care providers and community-based organizations.

Maine's Robert Wood Johnson Turning Point Grant resulted in a recommendation for a regional public health infrastructure (RPHI). Many of the Turning Point recommendations were addressed in the Governor's Dirigo Health Plan legislation in 2003. The Governor's Office of Health, Policy, and Finance lead the discussion regarding RPHI. A PH Workgroup was convened in 2005 and charged with outlining a regional structure. Maine's 2006-2007 State Health Plan (SHP) included objectives to build a statewide public health infrastructure (PHI) for the purposes of improving efficient and effective PH capacity and delivery of the 10 essential PH services and three core functions of PH statewide. The emerging infrastructure includes a statewide network of Comprehensive Community Health Coalitions; an enhanced Local Health Officer system; eight DHHS Districts, each with a District Coordinating Council (DCC) for PH; Maine CDC PH Units located in DHHS regional offices; existing Tribal and Municipal Health Departments, and Maine CDC and Office of Substance Abuse in the DHHS. In addition to the eight DHHS Districts, a Tribal PH District, staffed by Tribal PH Liaisons, was formed in order to enhance PH services for Maine's Tribal communities. The PH system will coordinate with and build upon the strengths of existing infrastructure that includes health care and education systems, family planning and MCH systems, other non-profit organizations, emergency management, and other regional and local government entities. The eight DHHS Districts are based on county lines and are as follows: Aroostook; Cumberland; Penquis; Downeast; Midcoast; Central Maine; Western Maine; and York. The DHHS Districts were chosen based on population, geographical spread, county borders and hospital service areas and are the same configuration as those used by the district court system and tourism bureau. The Maine DHHS recently adopted the same district boundaries and is implementing them within the child welfare and mental health sections within DHHS. The Tribal District encompasses lands and health departments of Maine's four federally-recognized tribes and is located in several areas in the northern part of the state and surrounded by three of the DHHS Districts. PH Units of the Maine CDC are now aligned to serve the DHHS Districts. Each DHHS and Tribal District has convened a DCC as a collaborative interface between local and state PH entities. The DCCs help assure coordinated, effective and efficient PH delivery in each district. They are also responsible for developing district public health improvement plans (DPHIP) and their planning will contribute to the SHP as well as local health planning efforts.

A statewide Coordinating Council (SCC) was formed and will build upon the work of the PH Workgroup to implement a statewide PHI that assures a more coordinated system for delivery of PH services. Division of Local Public Health (DLPH) activities to date include: setting up the DLPH, hiring District PH liaisons, developing a Local Health Officer Training, forming DCCs in all districts, conducting Local PH System Assessments in all eight DHHS Districts, and providing assistance around the Mobilizing for Action Through Planning and Partnerships (MAPP) assessments. The MAPP assessments were completed in 2011 and are included in the DPHIPs. /2012/ DPHIP implementation is underway, plans can be found at: http://www.maine.gov/dhhs/boh/olph/dphip/index.shtml

In September of 2010 Maine was awarded a five-year $4.2 million infrastructure grant from the federal DHHS. Funded by the Affordable Care Act of 2010, the goal of these funds is to assist the Maine CDC in improving its performance management capacity to meet national public health standards. Maine will utilize these funds to complete an electronic death certificate system, update an electronic birth certificate system, build systems to allow health care providers to more easily transfer immunization information to Maine CDC, improve capacity for health planning at the state and district level, and make PH data more accessible. //2012//

Looking at the conceptual framework for the services of the Title V MCHBG, Maine's resources have fallen more heavily within the Direct Services (DS) area resulting from the state's limited local resources. Over the past 14 years, under the direction of Valerie Ricker, the Title V Program has shifted its priorities from primarily funding direct MCH services to also supporting efforts and projects that promote development of family-centered MCH systems of services and care. The emphasis has shifted from relying on the MCHBG for DS provision to using it as an innovative planning and system building tool in promoting better health and developmental outcomes. Thus, we have adjusted the balance of human and financial resources so they are more in alignment with Title V's role in strengthening PH capacity and infrastructure at the local and regional level. The beauty of Title V is that it gives states the flexibility to adjust their role and function to that of placing a greater focus on core PH functions and quality assurance in relation to DSs provided at the local and regional level. Maine's Title V activities, by level of the pyramid for the MCH population, are summarized in the attached Table 3.

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

In late 2008, the priority setting process began with Maine's Division of Family Health (DFH) senior leadership team and program staff designing an objective and deliberate process for the selection of the 2010 priorities. The overall goal was to compile a set of priorities, based on strengths, needs and assets to assist in guiding the DFH's work over the next five years. To ensure widespread investment in the chosen priorities, there was significant staff and stakeholder involvement in the selection of priorities. Consensus about the proposed process was reached in March 2009 among DFH program managers and stakeholders.

The process for selection of the priorities for 2010 changed considerably from 2005. One criterion in 2005 was a desire to be inclusive in the priorities selected, and to capture a wide array of needs within the priorities. By contrast, in 2010, there was consensus among MCH programs and stakeholders that the 2005 priorities were too broad and thus a deliberate attempt was made to be specific with each priority. The priorities selected for the next five years were developed based upon an in-depth analysis of the health of the MCH population through quantitative and qualitative data.

/2012/ During FY11 the DFH convened ten groups of stakeholders with knowledge and/or expertise in each priority area to participate in two half day meetings. The purpose of the meetings was to learn from participants what in Maine is contributing to the problem (priority), what evidence-based programs are in place to address the priority, how participants can partner

or support these efforts, or what strategies could be undertaken to address the priority.

With budget pressures anticipated to continue into the future, participants were encouraged to select strategies that compliment efforts of other partners and where improvement can be achieved over the next five years. Action plans are being developed in a manner that accounts for capacity (human and financial) of participants (key partners and DFH programs) to implement with the expectation of level or decreased funding.

For each priority area, an action plan is being developed, however they look different for different groups. For some groups there are strategic plans or grant work plans in place that contain goals, objectives and strategies to address priorities (i.e., Autism). For others, plans are in place to undertake a strategic planning process during FY12 (Intentional and Unintentional Injury) and these groups will submit an action plan once their strategic plan is completed. Yet for others like family planning, adolescent sexuality, violence against women, child and adolescent mental health, women's mental health, and childhood exposure to violence; goals, objectives and strategies have to be developed. The state performance measure selected will assess progress on each priority. The action plan for our Autism priority is attached as an example of the work underway. //2012// ***/2013/ Competing priorities prevented the Intentional and Unintentional Injury Program, as well as the women's and child and adolescent mental health groups from completing their action plans. We anticipate they will be completed by early Fall 2012. //2013//***

The 10 priorities (in no particular order) selected in 2010 and rationales are as follows:

a. Suicide and Self-inflicted Injury: Reduce suicide and self-inflicted injury in the maternal and child population in
Maine.

Suicide is the second leading cause of death among youth and the 4th leading cause of death among women age 15-44 years in Maine. Each year, approximately 1 in 10 adolescents consider taking their own lives. The impact of suicide is devastating to survivors including family, friends, schools and entire communities. Risks for suicide include poor mental health, substance abuse, and trauma.

Progress on this priority will be measured using NPM #16 and SPM #1 (new in 2011).

Other related measures include: SPM #2, SPM #6, SPM #7

b. Violence Against Women: Reduce the prevalence of domestic violence and sexual assault and associated
health disparities.

Every year over 7,000 Maine women are physically or sexually assaulted by an intimate partner. In 2008, approximately 48% of homicides in Maine were related to domestic conflicts. In the same year 373 rapes were reported to law enforcement, a 19% increase from 2004. Violence against women is linked to poor physical and mental health outcomes for women and children, such as depression, suicide, sexually transmitted infections, unwanted pregnancies, traumatic brain injury, and chronic pain. A public health approach to the problem is essential to preventing violence before it occurs and reducing its harmful effects.

Progress on this priority will be measured using SPM # 2 (new in 2011)

Other related measures include: SPM#1, SPM #4, SPM #6, SPM #7

c. Obesity and Overweight: Reduce the prevalence of overweight and obesity among children and adults in

Maine.

In Maine, like the rest of the nation, obesity and its associated health consequences are increasing exponentially. Data from 2009 show the problem is pervasive from youth to adulthood. Almost 2 out of 3 Maine adults (64%) are considered either overweight (38%) or obese (26%). The percent of obese adults in Maine has increased 87% since 1995 when 14.1% of Maine adults were obese. In 2009, according to the Maine Integrated Youth Health Survey, about 1 in 4 Maine high school and middle school students (26.4%, 26.2% respectively), 30.5% of 5th and 6th graders, and 33% of kindergarten and third graders were overweight or obese. Obesity is a risk factor for chronic conditions, such as heart disease, diabetes, cancer, and arthritis, and is associated with premature death. Obesity is the number-two killer, after tobacco, in total number of deaths due to preventable causes. Encouraging state-wide efforts that help people achieve recommended levels of physical activity and proper nutrition is critical to improving the long-term health of Maine's MCH population.

Progress on this priority will be measured using: NPM #14 and SPM #3 (new in 2011); additional data will be available from Maine's CHIPRA grant

d. Family Planning: Improve reproductive health outcomes for Maine women.

By improving women's reproductive health, we can improve women's health and infant birth outcomes. This priority encompasses unintended pregnancy, access to contraception, pre-conception care, as well as birth outcomes. Public health actions can greatly impact women's reproductive health. Education regarding contraception and available and affordable methods of birth control are crucial in reducing the number of unintended pregnancies. Increased awareness of preconception health and family planning may improve the chance of having a healthy baby.

Progress on this priority will be measured using: NPM #08, #15, # 18, HSCI # 04, HSI #01A, #01B, #02A #02B #05A, #05B, SPM #4 (continued from 2005)

Other related measures include: SPM #2, SPM #6

e. Child and Adolescent Mental Health: Improve behavioral/mental health and trauma status of infants, children
and adolescents by offering responsive support, services and educational information.

Historically, the role of trauma was underestimated within the youth population. SAMHSA recently reported that 39% of children have experienced trauma. Research informs us that exposure to trauma even in utero can have profound and lasting implications on children's mental health and well-being. Early responsive intervention is essential and serves as a primary prevention tool for mental health/behavioral and addiction issues. Developing early intervention services and trauma responsive services and supports is the foundation for changing current rates of mental health and behavioral problems in our 18 and under population.

Progress on this priority will be measured using: NPM#16

Other related measures include: SPM#2, SPM #7

A new state performance measure on child and adolescent mental health will be developed after we identify the areas of children's mental health where Maine's Title V agency will focus its efforts.

f. Autism: Ensure early identification and a comprehensive and coordinated family-centered system of care for
children with autism spectrum disorder.

Maine will ensure that all children with ASD/DD are identified as soon as possible in order for the child and family to receive the full benefit of early intervention services and supports. Public and private entities will work together with families to ensure intervention services and supports will be effective, accessible, coordinated, comprehensive, of high quality, and delivered in a culturally competent manner. All services and supports for children with ASD/DD will be incorporated into a comprehensive family-centered system of care, with continuous quality improvement.

Progress on this priority will be measured using: NPM#2, #3, #5 and SPM # 8 (new in 2013)

g. Unintentional Injury: Reduce the incidence of unintentional injuries to Maine's MCH population.

In Maine, during 2002-2006, unintentional injuries were the leading cause of death among 1-44 year old residents. Unintentional motor vehicle traffic crashes were the leading cause of injury deaths for children and youth ages 1-24 and unintentional poisoning was the second leading cause of death among those age 15-24 years. Injuries are a preventable public health problem and reducing injuries and the resulting disabilities and deaths are among the objectives of Healthy Maine 2010 and Healthy People 2010. A solid injury prevention infrastructure in the state health agency is essential to reducing the burden of injury.

Progress on this priority will be measured using: NPM #10, HSI #03A, #03B, #03C, #04A, #04B, and #04C, SPM #5 (new in 2011)

h. Adolescent Sexuality: Improve adolescent sexual health.

Adolescent sexual activity, including vaginal, anal, and oral intercourse, carries the risk of unintended pregnancy and STD transmission. In 2007, 45% of Maine high school students reported ever having had sexual intercourse, 5% before age 13. Additionally, 41% of teens did not use a condom during their last sexual intercourse and 20% were under the influence of drugs or alcohol before their last sexual intercourse. In Maine, teen pregnancy rates declined by 41% from 1991-2006 compared to a 32% decline nationally. However, similar to the U.S., Maine has seen its teen birth rate increase in recent years. Continued initiatives by state sponsored agencies are necessary to reduce pregnancy rates and the incidence of STDs among teens and young adults in order to ensure the best future for all Maine youths.

Progress on this priority will be measured using: NPM # 08, HSI #05A

i. Women's Mental Health: Improve women's mental health and access to mental health treatment for women
suffering from a mental health condition, including postpartum depression.

More than 1 in 4 women in Maine have ever been diagnosed with depression or have current symptoms of depression. Women are more likely than men to have higher rates of disorders such as major depression, anxiety, posttraumatic stress disorder, and eating disorders. Risks for mental illness can be biological, social and neurological. Women are vulnerable to depression around the time of pregnancy and during the postpartum period. In addition, trauma-related experiences during childhood and adulthood can increase risk for mental illness. There is evidence based on the Adverse Childhood Experience study that early trauma can have life-long effects on physical and mental health. Recent studies suggest that counseling that integrates trauma, mental health, and substance abuse disorders, is associated with improved outcomes. However, a challenge for many who are suffering with a mental health disorder in Maine is finding and accessing treatment.

Progress on this priority will be measured using: SPM # 6 (new in 2011)

Other related measures include: SPM #1, SPM #2 SPM #4

j. Childhood Exposure to Violence: Reduce children's exposure to violence at home, in school and the community.

Violence experienced during childhood is a major, worldwide public health problem. Children can be exposed to a wide range of traumatic events including injury to self, witnessing serious injury or the death of others, or experiencing the imminent threat of injury or death to self or others. Traumatic events may elicit overwhelming feelings of terror and helplessness. They may be acute, occurring at a particular place and time like a physical assault or disaster or terror event; or they may be events that occur repeatedly over an extended period of time. A history of exposure to violence or experiencing trauma can have a significant negative effect on a child's behavior, development and can make it more likely that an individual will engage in tobacco use and or substance abuse, criminal activity, teen pregnancy and self-injurious behavior including suicidality.

Progress on this priority will be measured using: SPM # 7 (new in 2011), SPM #2

Related measures include: SPM #1, SPM #4 SPM #6

The Maine Title V Program has selected 8 performance measures related to the above priorities; they are;

1. The rate of suicide deaths (per 100,000) among those age 20-44 years.

This measure was chosen because the MIPP is expanding its efforts to address suicide and self-inflicted injury across the lifespan. The number of suicides among males and females in this age group is among the highest of any age group in Maine. When an adult dies by suicide, it can have serious consequences for the families and children who are survivors. Data from this measure are from death certificates maintained by the Maine DRVS within the Maine CDC.

2. The percent of adult women reporting sexual assault or intimate partner violence within the previous 12
months.

By reducing the occurrence of domestic violence and sexual assault, we can reduce the consequences. Data from this measure come from the Maine BRFSS System. Maine's Title V program is committed to maintaining questions on the BRFSS to track this outcome over time.

3. Percent of students in grades 5-12 who are overweight or obese.

Children who are overweight or obese are at increased risk of becoming overweight adults and developing chronic conditions, such as Type II diabetes, at a young age. Establishing healthy lifestyle habits among children decreases this risk. Data for this measure are from the Maine Integrated Youth Health Survey.

4. The rate of unintended births among women less than 24 years of age.

Unintended births in Maine among young women have steadily increased over time. Unintended pregnancy can be a consequence of preconception factors such as access to contraception, substance use, and intimate partner violence. The consequences of unintended pregnancy include inadequate prenatal care, poor birth outcomes, postpartum depression, and child maltreatment. This SPM was included as part of the 2005 CSNA and we have chosen to maintain it for this priority. The data are from Maine's Pregnancy Risk Assessment Monitoring System.

5. The hospitalization rate (per 10,000) of unintentional poisonings among children and youth

aged 0-24 years.

The MIPP, through its CDC Injury Core Capacity grant, has two priorities related to unintentional injury that apply to the MCH population: (1) motor vehicle crashes, and (2) unintentional poisoning. There is a national performance measure and several health status indicators related to motor vehicle crashes and unintentional injury mortality and hospitalization. Unintentional poisoning has been increasing in the state and MIPP has been working with the Northern New England Poison Control Center and the Maine Office of Substance Abuse to examine and address the problem. Data for this measure come from the Maine Hospital Discharge Dataset, which is produced on an annual basis by the Maine Health Data Organization.

6. The percent of women with depressive symptoms receiving medication or treatment for a mental health or emotional condition by a doctor or other healthcare provider.

The determinants of mental illness can be biological, social, and neurological. They can include experiences with violence as an adult or child, stressful life events, and lack of social support. It is critical that health care providers screen for signs of mental distress and help patients receive needed treatment. Research suggests that primary care providers can play a critical role in detecting and treating depressive symptoms. This measure will help us assess whether women who are struggling with depression are receiving care. Data are from the Maine BRFSS.

7. The rate of substantiated cases of child abuse and neglect assessed by Maine's Office of Child and Family
Services.

Although childhood exposure to violence can occur outside of the home in schools and communities, we have selected to measure childhood exposure to violence in the home. Childhood maltreatment has been linked to poor health outcomes throughout the lifespan including mental illness, chronic disease, substance use, and disability or death. The data for this measure are collected by Maine's Office of Child and Family Services. By reducing children's exposure to violence, we will decrease the number of cases assessed by the state for maltreatment.

8. The percent of children aged 12-36 months enrolled in Medicaid who have had a claim for a social, emotional
or behavioral developmental screening test.

Maine chose this measure to ensure that all children with autism spectrum disorder/developmental disabilities are identified as soon as possible so that the child and family can receive the full benefit of early intervention services and supports. We will work with our Medicaid agency over the next year to obtain baseline data for this measure.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	91.3

Numerator	18	32	20	23	21
Denominator	18	32	20	23	23
Data Source		Maine Newborn Screening Program	Maine Newborn Screening Program	Maine Newborn Screening Program	Maine Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center). Data are from Maine's Newborn Screening Program.

Notes - 2010
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center). Data are from Maine's Newborn Screening Program.

Notes - 2009
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center). Data are from Maine's Newborn Screening Program.

Starting July 1, 2008, Maine started screening for cystic fibrosis. In 2009, 13,285 infants were screened and 9 were confirmed through sweat tests to have the condition. All are currently receiving treatment.

a. Last Year's Accomplishments
Maine participates with the New England Newborn Screening Program in a regional effort to assure babies receive timely, accurate, high quality screening and receive timely follow-up. Program staff report abnormal screens to the primary care physician (PCP) including recommendations for evaluation and follow-up and make referrals to appropriate specialty providers. All clinically significant abnormal results are reported out within 24 business hours of receipt based on the urgency of the results. A phone call is made to the PCP with a follow-up result letter outlining the phone discussion. If there is a high likelihood of the child having the disorder, Maine CDC Newborn Bloodspot Screening Program (NBSP) staff contact the PCP the following business day to confirm they were able to reach the family to check on the baby's

condition, as well as consult with the Specialist who was informed by the NBSP to discuss clinical status and next steps. NBSP staff monitors for repeat specimens and communicate with specialty clinics to assure children enter into care and receive appropriate treatment. Approximately 95% of results are reported out the day they are received. The remaining 5% were either not urgent results, staff were unable to reach the PCP, or the PCP and the NBSP was unable to locate the family. Our contract with the New England NBSP Laboratory includes program coverage on days when NBSP staff are not available to ensure no delays in reporting urgent or significant results.

The data for this measure come from Maine's NBSP. 100% of newborns that screened positive for one of 32 disorders monitored by Maine's NBSP panel in 2011 had timely follow-up to definitive diagnosis and clinical management. Maine has maintained this high standard since at least 2002.

Maine consistently screens over 99% of infants born in the state. During CY11 Maine screened 12,489 of the 12,568 births that occurred in the state. Of these, 23 were identified with disorders, including nine newborns confirmed to have cystic fibrosis (CF) and nine newborns confirmed to have congenital hypothyroidism. Those infants not screened either died in the first few days of life (54) or parents refused screening (25) [20 were homebirths 80% of all refusals]. All infants with urgent lab results received appropriate consultation and diagnosis was confirmed, treatment was initiated within 48 hours (in most cases 24 hours) of out-of-range lab results known to the program. Maine's success can be attributed to our ability to link metabolic screening data with birth certificate data. Maine has also developed a close working relationship with our two specialty centers thus ensuring timely follow-up for infants. Maine has two major medical centers that have Genetic Programs and CF Clinics. The Maine NBSP benefits from consultation with these specialists, including metabolism, endocrinology, hematology and pulmonology. The NBSP also consults with MaineCare Member Services to assist with tracking infants and identifying current contact information for families and primary care providers.

The National Secretary Advisory Committee on Heritable Disorders in Children has made a recommendation for all states to add Severe Combined Immunodeficiency (SCID) to state screening panels. The NBSP Advisory Committee recommended SCID be added as a screened condition and the Department approved the recommendation.

In CY 2011 there were multiple staffing changes at Eastern Maine Medical Center (EMMC) related to specialty pediatrics. The Geneticist position was filled after being vacant for nearly two years, a Genetic Counselor was hired to staff a one-day a week genetics clinic and a RN was hired to manage the CF clinic. The limited staff for the EMMC clinic genetics clinic has resulted in a six month waiting list. Families can be seen sooner if there is an alternative as six months is not acceptable, in many cases, to wait for an appointment.

The NBSP Nurse Coordinator continues to act as clinic liaison for metabolic and CF clinics at both care centers. Annual visits are made to all four clinics to evaluate effectiveness of the screening system and changes are made as necessary. A lack of access to prescribed foods and formula for Maine individuals with Inborn Errors of Metabolism (IEM) has been a persistent problem.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Finalize program policies and procedures.				X
2. Evaluate and make final recommendations regarding Cystic Fibrosis (CF) Center Affiliate status for Eastern Maine Medical Center CF clinic.				X
3. Continue active role in ongoing quality improvement				X

workgroup.				
4. Partner with New England states in critical congenital heart disease pilot.			X	X
5. Implement/evaluate effectiveness of NICU protocols.				X
6. Continue participation on New England Genetics Collaborative.				X
7.				
8.				
9.				
10.				

b. Current Activities
The NBSP provides technical assistance to the EMMC CF Clinic, through a contract with a CF nurse, to assess clinic functions and make recommendations for improvements to assure EMMC meets the credentialing requirements for CF Foundation Affiliate Center status. Failure to meet credentialing requirements has the potential to significantly impact access to specialty care for approximately 100 individuals with CF.

The addition of charting and reporting specific lab tests electronically through secure email systems led to a refinement of reporting and follow-up methods that have proven to be a more efficient and effective way of reporting and tracking individual screening and evaluation activity. These changes include electronically reporting serial lab results for individuals with PKU that are monitored by the metabolic clinics, facilitating improvement of laboratory data management to the ChildLINK database, and using the laboratory database narrative charting capabilities for case management as opposed to paper charting.

A quality improvement workgroup was developed to evaluate the experience of Maine individuals with IEM and barriers experienced accessing prescribed foods and formula needed for evidenced-based treatment and care. Liz Plummer, RN is leading the group and the initiatives which include surveys to families and pharmacists, a presentation to Maine CDC Director, Dr Sheila Pinnette, a pilot study, and potential publication of findings. (Project Storyboard attached)

An attachment is included in this section. IVC_NPM01_Current Activities

c. Plan for the Coming Year
A planned three month leave of absence of the NBSP Nurse Coordinator will create a staffing shortage. Reporting results and collaboration with primary care providers and specialists to assure access to evaluation and treatment will continue to be a priority and will be managed by existing RN program staff.

Maine has continued to set an objective of 100% for this measure and we will continue to communicate with PCPs and Specialists to maintain our current follow-up rate.

The NBSP will continue to collaborate with statewide CF Centers and evaluate services provided and ensure the needs of all Maine patients with a diagnosis of CF are met.

The NBSP will finalize program policies and procedures in final preparation for State Health Department Accreditation.

During FY12 the NBSP initiated the planning phase for adding SCID to the panel of conditions screened. A multidisciplinary workgroup was formed to assure input and guidance from immunologists, infectious disease specialists, emergency physicians and primary care providers. This group will adopt clinical follow-up protocols and materials related to SCID screening. Provider education will take place with grand round presentations at several hospitals and parent

education materials will be developed. SCID screening will not be implemented until all necessary systems for testing and treatment are established.

Efforts will continue to enhance and more fully integrate newborn screening data into ChildLINK, an electronic data tracking and surveillance system that currently houses newborn hearing and birth defects data and information on births and deaths of children, to allow for accurate documentation. This will also assist in long-term follow-up of children. Once an infant is identified and confirmed to have a disorder, the appropriate information will be added to ChildLINK for tracking and follow-up. Efforts will continue to create Quality Assurance modules in ChildLINK to monitor program effectiveness.

Several Maine birthing hospitals are beginning to implement newborn screening for Critical Congenital Heart Disease (CCHD). Maine participated in a regional application to HRSA for a CCHD demonstration grant. Maine Health Systems, the largest medical center in Maine which includes nine other partner or affiliate member hospitals, is the primary implementation site. The New England Genetics Collaborative (NEGC) is the applicant organization.

Neonatal intensive care unit (NICU) protocols will be implemented and effectiveness evaluated.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12700**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	12489	98.3	30	0	0	
Congenital Hypothyroidism (Classical)	12489	98.3	137	9	9	100.0
Galactosemia (Classical)	12489	98.3	3	0	0	
Sickle Cell Disease	12489	98.3	1	1	1	100.0
Biotinidase Deficiency	12489	98.3	7	1	1	100.0
Cystic Fibrosis	12489	98.3	77	9	9	100.0
Homocystinuria	12489	98.3	61	0	0	
Maple Syrup Urine Disease	12489	98.3	16	0	0	
Toxoplasmosis	23	0.2	0	0	0	
21-Hydroxylase	12489	98.3	42	0	0	

Deficient Congenital Adrenal Hyperplasia						
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	12489	98.3	3	0	0	
"Expanded metabolics"	12489	98.3	44	3	3	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	65	60.7	60.7	60.7	65
Annual Indicator	60.7	60.7	60.7	74.5	74.5
Numerator					
Denominator					
Data Source		NSCSHCN 2005/2006	NSCSHCN 2005/2006	NSCSHCN 2009-10	NSCSHCN 2009-10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	76	77	78	79

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Denominator: CSHCN age 0 -17 years

Numerator: CSHCN whose families usually or always feel that they are partners in decision making around issues important to their child's health; Outcome not successfully achieved

Revisions and Changes: The items used to develop this measure were revised substantially between 2005/06 and 2009/10. This measure is now based on whether CSHCN have families who usually or always feel that they: 1) discuss with providers a range of options to consider for their child's treatment; 2) are encouraged to ask questions or raise concerns; 3) it is easy to ask questions or raise concerns; and 4) their health care providers consider and respect what treatment choices the parent feels would be best for child.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.

Denominator: CSHCN age 0 -17 years

Numerator: CSHCN whose families usually or always feel that they are partners in decision making around issues important to their child's health; Outcome not successfully achieved

Revisions and Changes: The items used to develop this measure were revised substantially between 2005/06 and 2009/10. This measure is now based on whether CSHCN have families who usually or always feel that they: 1) discuss with providers a range of options to consider for their child's treatment; 2) are encouraged to ask questions or raise concerns; 3) it is easy to ask questions or raise concerns; and 4) their health care providers consider and respect what treatment choices the parent feels would be best for child.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Maine's value on this indicator is comparable to the national indicator of 57.4%. An objective of 65% is projected for the next administration of the survey. The objective for 2010 is based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

a. Last Year's Accomplishments
Maine's Children with Special Health Needs (CSHN) Program values the input it receives from the families it serves and works diligently to ensure families are involved in decisions regarding their child's health and services received from health care providers and the CSHN Program.

Data from the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) indicated that 3 out of 4 (74.5%) Maine families partner in decision making and are satisfied with the services they receive. There was a significant change in this measure between the 2001, 2005/2006 NS-CSHCN surveys and the 2009/2010 NS-CSHCN so the data are not comparable over time. Maine was comparable to the national average on this indicator ranking 11th highest overall in the United States.

Families are actively involved in all aspects of the CSHN Program and are represented on all CSHN sponsored advisory councils; these include: the Joint Advisory Council for Newborn Screening and CSHN (JAC), family members co-chair the council; the Acquired Brain Injury Advisory Council (ABIAC), family members and individuals participated on many sub-committees

and continued to make recommendations to the Brain Injury Program within the Office of Adults with Physical and Cognitive Disability; the Family Advisory Council (FAC) meets several times a year; the Birth Defects Advisory; and the Newborn Hearing Program Advisory Committee providing insight and guidance in policy development.

The Family Consultant, Anna Cyr's, responsibilities include; organizing quarterly Family Advisory Committee meetings, working with the Family to Family (F2F) health regions through the Maine Parent Federation, attending Medicaid Advisory Committee meetings, and representing both Family Voices and CSHN on a variety of State committees. During the reporting period, Anna represented families of children and youth with special health care needs at many venues including the MaineCare Advisory Committee, the Children's Health Insurance Program Reauthorization Act: Improving Health Outcomes for Children Project, Maine Children's Health Improvement Partnership, and the Maine Alliance of Family Organizations. Anna continued her advocacy work by supporting families through continued collaboration with the Disability Rights Center and the Developmental Disabilities Council. Anna supervises the New Mainer Program Coordinator who works with the Somali community in Lewiston. These activities have provided Anna with an opportunity to review the system of care that families must navigate in order to receive services for their children and has inspired her to think creatively and work towards the development of a family leadership program in Maine.

The Family Consultant completed a year-long Family Leadership Mentoring Program through AMCHP. This program provided Ms. Cyr with an opportunity to enhance her knowledge of systems at the national, state, and local level that address issues impacting women, children and families including CYSHCN and utilize the acquired skills to mentor family leaders from New Hampshire, Massachusetts, Rhode Island and Vermont. Anna also facilitates the AMCHP Family and Youth Committee; the focus of this group is development of youth leaders.

The CSHN program developed a brochure describing its transition to care-coordination and how this resource would benefit families. The brochure is available at: www.mainepublichealth.gov/cshn under the Partners in Care Coordination tab.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to recognize families as partners through the Family Advisory Council, Joint Advisory Council, Acquired Brain Injury Advisory Council and Newborn Hearing Screening Council.		X	X	X
2. Continue to have parents complete Form 13 and expand to family members on other councils.		X	X	X
3. Continue active family participation on all MCH boards and councils.		X	X	X
4. Continue to use the CSHN program website as a mechanism to disseminate information.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A Quality Improvement Workgroup (QI) engaged families in designing a family survey to evaluate experiences of Maine individuals with inborn errors of metabolism (IEM) and barriers experienced

accessing prescribed foods and formula needed for evidence-based treatment and care. Twenty-nine out of a total 63 families responded to the survey. Results indicated that reimbursement rates for formula are very low for both private and public insurance; pharmacies do not stock formula requiring families to order their product in a timely manner so it is in stock when needed. Families continue to bear the costs of specialty foods, although some private insurers cover a small percentage. MaineCare does not cover specialty foods, however those families who are eligible for CSHN services report having no problems accessing foods.

The QI Workgroup is currently surveying pharmacists to learn, from their perspective, potential barriers related to ordering formula for IEM individuals.

The Family Consultant co-chairs the Foods and Formula Workgroup; the group is engaging parents in developing a tip sheet, designed for pharmacists, that includes information on IEM, frequency of need for formula, and when parents will be ordering formula so there are no delays.

The Family Consultant, Anna Cyr applied for and was accepted in the 2012-2013 cohort for the MCH Public Health Leadership Institute at the University of North Carolina.

c. Plan for the Coming Year

Maine's objectives for this measure shifted upward with the new measurement of this indicator. Given our efforts in this area, our shift towards infrastructure building and the use of a family survey, and our efforts to actively involve families and youth at various levels, we anticipate that we will succeed in reaching our objective. We anticipate that families and youth will work with the F2F Health Information Center partners to create systems that ensure children, youth and family needs are met.

The CSHN Program will continue to utilize quality improvement methods to assure efficient and effective achievement of program goals and objectives.

During FY13 the CSHN Program will focus on fully developing and providing leadership training for the six regional FACs. Our family consultant, Anna Cyr, will conduct the trainings.

The JAC, Newborn Hearing Screening Advisory Board, ABIAC and FAC will continue to provide advice and recommendations to the CSHN Program and the Office on Brain Injury on policy and development.

As a new AMCHP family leader mentor, Anna will move forward with developing a Family Leadership Program in Maine. This opportunity will enhance her work with the Maine Family Advisory Council in utilizing their skills and knowledge in development of the program.

With input from the Family Consultant, the CSHN Program will update the family section of the CSHN website.

The CSHN Program will update legislative rules to align with its transition from providing direct services to a population-based and infrastructure based program focus.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011

Performance Data					
Annual Performance Objective	65	51.7	51.7	51.7	55
Annual Indicator	51.7	51.7	51.7	47.5	47.5
Numerator					
Denominator					
Data Source		NSCSHCN 2005/2006	NSCSHCN 2005/2006	NSCSHCN 2009/2010	NSCSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	48.5	49.5	50.5	51.5	52.5

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Denominator: CSHCN age 0 -17 years

Numerator: CSHCN receiving adequate care on all needed components of medical home assessed by the survey; CSHCN who did not achieve this outcome

Revisions and Changes: One minor revision was undertaken between the 2005/06 and 2009/10 NS-CSHCN surveys. An item assessing whether or not the child or child's family required an interpreter and whether or not the interpreter was usually or always provided was dropped from the survey due to low prevalence.

Notes - 2010
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Denominator: CSHCN age 0 -17 years

Numerator: CSHCN receiving adequate care on all needed components of medical home assessed by the survey; CSHCN who did not achieve this outcome

Revisions and Changes: One minor revision was undertaken between the 2005/06 and 2009/10 NS-CSHCN surveys. An item assessing whether or not the child or child's family required an interpreter and whether or not the interpreter was usually or always provided was dropped from the survey due to low prevalence.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Given the changes in this indicator between the two CSHCN Surveys, we have adjusted our objective for future years to 55%.

a. Last Year's Accomplishments
Data from the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) for Maine indicate that slightly less than half of parents (47.5%) with a CSHN received coordinated, ongoing, comprehensive care within a medical home. This is not statistically different from Maine's result on the 2005/2006 NS-CSHCN and is no different from the U.S. percentage on this measure (43.0%). Maine ranked 10th highest overall in the U.S. on this measure.

MaineCare Member Services (MMS) Early Periodic Screening Diagnosis and Treatment (EPSDT) in the Division of Population Health is responsible for assuring that MaineCare members under the age of 21 who receive full MaineCare benefits are informed of and receive the services and assistance available to them under the MaineCare Program. As a result of the MMS relationship with Title V, the Title V program now plays a more active role in ensuring that children receive ongoing, coordinated access to medical care.

CSHN is represented on the EPSDT Planning and Information Committee and provided recommendations to MaineCare on Newborn Hearing, Birth Defects around pre-maturity and Newborn Bloodspot surveillance and tracking programs. The Committee's primary role is to ensure that primary care is accessible, continuous and comprehensive. The CSHN Program's MMS Initiative is working with MaineCare on reducing the number of children insured through MaineCare who are lost to follow-up between diagnosis and receiving early intervention services. During CY11 MaineCare Member Services made approximately 13,380 calls to members.

In 2009 Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition (MHMC) convened a multi-stakeholder effort to implement a Patient Centered Medical Home (PCMH) model. The collaborative worked with all major private payers in the state and MaineCare to develop an alternative payment model that recognizes the infrastructure and system investments needed to deliver primary care in accordance with the PCMH model and rewards practices for demonstrating high quality and efficient care. The ultimate goal of this effort is to sustain and revitalize primary care to both improve health outcomes for all Maine people and reduce overall healthcare costs. A key component of this initiative is inclusion of consumers (patients) in redesigning care with practices. A diverse group of 22 adult and 4 pediatric practices from across the state were selected to participate in this demonstration project that started in January 2010. According to the MHMC, over the first year of the pilot Maine saw early positive results in terms of both quality improvement and cost control. The CSHN Program, through its HRSA/MCHB State Implementation Grant for Autism Spectrum Disorder and Other Developmental Delays, is working with the 4 pediatric practices to implement developmental screening.

Maine is the only state that included pediatrics in its All-payer PCMH Pilot Project. To implement

measurable quality improvement, the pediatric pilot has adopted the Children's Health Insurance Program Reauthorization Act (CHIPRA) measures described by the Agency for Health Research Quality.

Through the CHIPRA grant, Maine and Vermont are promoting the use of quality measures and information technology to improve health outcomes for children, by improving Medicaid member children's timely access to quality care. Some activities undertaken by Maine are: collect and evaluate the CHIPRA core measures, a set of pediatric quality measures identified by a federal panel of experts, and additional pediatric quality measures identified by Maine stakeholders; design, develop and implement health information technology linkages and systems within Maine DHHS services and with medical practices and health systems to collect and report EPSDT/Bright Futures preventive measures; design, implement and evaluate an electronic health assessment for children in Maine's child welfare foster care system; and develop and implement "Learning Community" activities with the PCMH Pilot and other medical practices to enhance practice-level capacity for child health quality improvement and to evaluate the impact on quality.

The state Title V Director, CSHN Director and CSHN Family Consultant sit on the Improving Health Outcomes for Children (IHOC) Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue collaboration and partnership with the Maine Chapter of the AAP.			X	X
2. Participate at the Maine Chapter of AAP Annual Meeting.				X
3. Work with Patient Centered Medical Home Pediatric sites to ensure comprehensive, coordinated and family-centered values exist for all children including CSHN.				X
4. Work actively on the Children's Health Insurance Program Reauthorization Act project and in developing the Pediatric Quality Council.				X
5. Continue to work with MaineCare on EPSDT issues to enhance their ability to meet member needs.				X
6. Pending data availability, work with MaineCare on Newborn Hearing Screening and follow-up for babies born < 37 weeks.				X
7.				
8.				
9.				
10.				

b. Current Activities

Maine received additional Centers for Medicare and Medicaid Services funds in FY12 and the PCMH pilot will be expanding to add 20 new adult practices starting in January 2013.

In late FY12 MaineCare will broaden its support for practices that agree to meet medical home criteria and commit to the PCMH Pilot through its new "Health Homes" (HH) initiative, an effort authorized by Section 2703 of the Affordable Care Act. The MaineCare HH Initiative requires HHs to deliver the following key services: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social services; use of health information technology; prevention and treatment of mental illness and substance abuse disorders; and coordination of and access to preventive services, chronic disease management and long-term supports.

In the first stage of the HH initiative, qualified primary care practices will partner with a Community Care Team (CCT) to form a HH to serve MaineCare members with specific chronic conditions. In the second stage, qualified Community Mental Health Center-based CCTs will partner with primary care practices to serve adults with Serious and Persistent Mental Illness and/or children with Serious Emotional Disturbance. MaineCare will provide HH payments to qualified practices and CCTs to provide comprehensive, coordinated care.

c. Plan for the Coming Year
Maine is working to ensure that all children have a medical home and we hope to see improvement in this measure in the coming years. Based on the 2005/2006 NS-CSHCN, our goal for this measure was to have at least 55% of parents reporting that their child is receiving care through a medical home by the release of data from the 2009/2010 NS-CSHCN. We have adjusted this objective to 52% based on the most recent survey.

A report on CSHN is being created summarizing data from the NS-CSHCN 2009/2010, including the MCH performance objectives.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	70	70	70	70	75
Annual Indicator	70	70	70	70.2	70.2
Numerator					
Denominator					
Data Source		NSCSHCN 2005/2006	NSCSHCN 2005/2006	NSCSHCN 2009/2010	NSCSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70.5	71	71.5	72	72.5

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and

the U.S. Centers for Disease Control and Prevention in 2009-2010.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Denominator: CSHCN age 0 -17 years

Numerator: CSHCN whose private and/or public insurance coverage is continuous and adequate to meet the child's health needs; CSHCN who did not achieve this outcome

Revisions and Changes: These items are the same as those asked in 2005/06.

Notes - 2010
Indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Denominator: CSHCN age 0 -17 years

Numerator: CSHCN whose private and/or public insurance coverage is continuous and adequate to meet the child's health needs; CSHCN who did not achieve this outcome

Revisions and Changes: These items are the same as those asked in 2005/06.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN Survey.

Due to the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we are cautious about anticipating improvements in this measure over the next several years. However, given new health care reform initiatives, we have set our objectives to reflect improvement in this measure.

a. Last Year's Accomplishments
According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), 70% of families with CSHN in Maine reported that they had adequate private and/or public insurance to pay for services they needed. This is the same as the 2005/2006 survey result. In both survey years, Maine's rate was significantly higher than the national average. In 2009/2010, Maine ranked 3rd overall in the U.S. on this measure; 95% of Maine's CSHN were consistently insured during the 12 months prior to the survey and 98.3% had some form of health insurance at the time of the survey. Almost 40% (38.7%) of CSHN had private health insurance coverage only, 49.6% had public insurance only, and 10% had a combination of public and private insurance.

During CY11 the CSHN Program served 255 infants, children and youth; 17 were less than one year old. The Program continues to provide payment for special medical care, travel, lodging and food and formula for 111 children and youth.

During FY11 the Program continued to administer the Southern Maine Cleft Lip and Palate Clinic and supported the Northern Maine clinic at Eastern Maine Medical Center. Discussions were

initiated with Maine Medical Center to transition overall responsibility of the southern Maine clinic to Maine Medical Center however they expressed a desire to have the state CSHN program continue to administer the program. The CSHN Program continues to identify other options to transition the clinic. Approximately 220 children with cleft lip and/or palate are served annually by these clinics. 18-25 infants are born each year in Maine with clefts and five to ten are adopted from other countries.

On January 1, 2010 the Maine WIC Program and MaineCare (Medicaid) adopted a 2001 federal regulation identifying MaineCare as the primary payer of special/prescription formulas for individuals participating in both programs. WIC participants that are also MaineCare members now receive their special/prescription formulas through their MaineCare insurance. The MCH Medical Director held discussions with MaineCare to identify a payment mechanism for those CSHN (20) children with inborn errors of metabolism who receive special medical foods and who are covered by MaineCare, however there is no funding available to transfer this cost to MaineCare. Currently the CSHN Program covers the cost (up to $60,000/year) of special medical foods for these clients.

L.D. 1198, "An Act to Reform Insurance Coverage to Include Diagnosis for Autism Spectrum Disorders (ASD)" was passed on April 12, 2010. This bill requires group health policies to provide coverage for diagnosis and treatment of ASD for children five years and under. It is estimated, using claims data from FY09, that there are currently 681 MaineCare members (0-5 years old) with ASD.

The Patient Protection and Affordable Care Act (PPACA) was passed in March 2010 and included in this legislation are several provisions in the private insurance market that impact CSHN; increased coverage for children by prohibiting pre-existing condition exclusions, extending dependent coverage to age 26, waiting periods can not exceed 90 days, removal of lifetime benefit caps, and requires that preventive services be part of coverage and not subject to co-pays and deductibles. Medicaid is also required to conduct outreach and enrollment to vulnerable populations. We anticipate this legislation will improve access to services and health outcomes for Maine CSHN by providing a continuum of care that is so important for CSHN.

As we move from providing direct services we continue to assist families in navigating through barriers to enrollment and re-enrollment in MaineCare and link to necessary resources. We are working with families on seeking alternative methods for payment of services such as physical and occupational therapy, and review potential funding gaps in services for those families most in need by developing criteria for qualification to receive funds. It is worth noting that several new non-profit agencies have been established to assist families of children with special health care needs. CSHN staff met with these agencies to discuss CSHN and coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to build on the existing relationship with the Office of MaineCare Services.		X	X	X
2. Monitor changes in benefit plans both public and private.		X		X
3. Work with the National Catalyst Center to improve health care insurance and financing for children and youth with special health needs.		X		X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
In 2011, at the request of families, the CSHN Program initiated a quality improvement (QI) project on access to foods and formula for individuals with inborn errors of metabolism (IEM). Anecdotally we learned that IEM patients continue to experience difficulty obtaining medically necessary foods and formula to remain healthy. The QI Workgroup was initiating measures to address obstacles families face that include lack of reimbursement (private and public) and pharmacy access, when they learned of a recent MaineCare rule change that posed a significant challenge for IEM patients. Although coverage for most formulas would continue, access was through durable medical equipment specialists rather than pharmacies which meant families could no longer access formulas. Discussions with MaineCare and DHHS led to elimination of the rule change. CSHN is working with MaineCare on a communication plan to notify families and providers.

CSHN staff are disseminating (primary care practices, pediatric and family practices and families of children with birth defects) the Partner's in Care Coordination program brochure (http://www.maine.gov/dhhs/boh/cshn/carecoordination/resources.html) that outlines services to assist families in navigating and locating available resources.

c. Plan for the Coming Year
Maine's objective for this measure represents a substantial increase in this objective by the time of the next survey due to the passage of the Affordable Care Act. We will monitor changes in benefit plans, both public and private, for any potential impact on CSHN.

We will continue to monitor activities related to insurance changes at the federal (PPACA) and state levels and how those changes may impact services of both MaineCare and other insurances, provide input as appropriate on MaineCare service changes, and work with MaineCare to discuss services and assist families as needed. Both the current economic conditions and funding cuts have posed challenges for the CSHN Program to locate needed services for families. Ms. Lisa Brown liaises between families and MaineCare and has expressed a very positive experience in working with MaineCare in getting services for families.

Continue discussions with MaineCare on foods and formula issues, specifically the communication plan.

The CSHN Program will make available, on its website, data on children with special healthcare needs to include but not limited to State and Local Area Integrated Telephone Survey (SLAITS), National Survey of Children with Special Health Care Needs, Newborn Hearing, and Bloodspot Screening, and Birth Defects statistics; providing our stakeholders with information on the CSHN population.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	79	87.9	87.9	87.9	90
Annual Indicator	87.6	87.6	87.6	63.7	63.7
Numerator					
Denominator					
Data Source		NSCSHCN 2005/2006	NSCSHCN 2005/2006	NSCSHCN 2009/2010	NSCSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	64	65	66	67	68

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

Denominator: CSHCN age 0-17 years

Numerator: CSHCN whose families report no difficulties or frustration accessing services needed for their child in the past 12 months; CSHCN who did not achieve this outcome

Revisions and Changes: These items were substantially revised in 2009. This measure is now comprised of six difficulties with accessing care: 1) not eligible for services; 2) services not available in your area; 3) waiting lists or other problems getting appointments; 4) issues related to cost; 5) trouble getting the information you needed; 6) any other difficulties not mentioned AND an assessment of how often parents were frustrated in their efforts to get services. Those CSHCN in the numerator answered YES to one of the six difficulties and usually or always to the frustration item. This measure is not comparable to outcome #5 from the 2005/06 NS-CSHCN survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.

Denominator: CSHCN age 0-17 years

Numerator: CSHCN whose families report no difficulties or frustration accessing services needed for their child in the past 12 months; CSHCN who did not achieve this outcome

Revisions and Changes: These items were substantially revised in 2009. This measure is now comprised of six difficulties with accessing care: 1) not eligible for services; 2) services not available in your area; 3) waiting lists or other problems getting appointments; 4) issues related to cost; 5) trouble getting the information you needed; 6) any other difficulties not mentioned AND an assessment of how often parents were frustrated in their efforts to get services. Those CSHCN in the numerator answered YES to one of the six difficulties and usually or always to the frustration item. This measure is not comparable to outcome #5 from the 2005/06 NS-CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN Survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Approximately 63.7% of families with a CSHN in Maine report that community-based service systems are organized so they can use them easily according to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN). Due to changes in the wording and placement of the questions between the 2005/2006 and 2009/2010 NS-CSHCN, we cannot make any statements about changes with this measure. Maine's performance on this measure was slightly lower, but comparable to the national average of 89.1%. Maine ranked within the bottom third of states on this measure (38 out of 50).

Over the past several years the CSHN Program has been transitioning from direct services to a community-based system of services and expanding its role in linking families with, rather than providing payment for, medical services. The new program called Partners in Care Coordination (PCC) assists families, healthcare providers, and communities improve the health, development, and well-being of Maine's children with special health needs. The PCC program provides health, community and referral information to families of children and youth with special health needs.

Through the PCC, the CSHN Program has broadened its definition of children with special health needs served to include all CSHN not just condition specific children. The CSHN Program and the Family Consultant developed a brochure outlining the services offered by PCC. Family input was solicited to ensure the brochure was family centered. The brochure can be found at: www.mainepublichealth.gov/cshn under the Partners in Care Coordination tab. PCC is available to all children and families in Maine with a special health need regardless of income or medical condition. The design and implementation of PCC began in 2008, with Ms. Lisa Brown coordinating the effort. The CSHN Program receives calls from families on issues related to cognitive disabilities, autism, denials for services, in particular, durable medical equipment from MaineCare (Medicaid), and linking families to other agencies. Primary callers are family members followed by providers. The Birth Defects Program sends a PCC brochure to those families with a child identified with a birth defect. The brochure was also distributed to approximately 25 primary care physicians and all Child Development Services sites.

The CSHN program has successfully transitioned all but 37 children from provision of financial services. The children remaining are those with cleft lip and palate, cystic fibrosis, hemophilia and inborn errors of metabolism. These children have continued to receive payment for special medical services because other options do not exist to support their needs.

The MaineCare Early Periodic Screening, Diagnosis, and Treatment (EPSDT) focus during FY11 was on assuring that children birth-21 years adhere to the Bright Futures (BF) schedule. The CSHN program worked with MaineCare to contact families and address issues around the importance of maintaining the BF schedule. A staff member also conducted dental outreach with families to determine if they had a dentist and if not provide assistance in locating, as well as

assist families in obtaining other services offered by MaineCare. The federal recommendation that Title V work with the State Medicaid Program has enabled Maine to establish a nice collaborative relationship with MaineCare; MaineCare Member Services makes approximately 13,000 calls annually to families insured through MaineCare.

The CSHN program updated its website to make information more easily accessible across all programs; each program area has a family, provider and resource section. Program staff solicited input, from the Family Advisory and Youth Advisory Councils on revising the CSHN website. They engaged families and youth to review the overall organization of the website for ease of use by those accessing information.

The CSHN Program also provided updated information on its services with 2-1-1 Maine, a statewide directory of health and human services that is accessible 24 hours a day, seven days a week.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate activities among MCHB funded initiatives.				X
2. Support the six regional Family to Family Health Information Coordinators.				X
3. Update the CSHN website to include sections for families, providers and other resources.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHN staff work with dental providers to increase participation rates of MaineCare insured patients. At one clinic the number of no-shows was reduced from 150 per month to 15. CSHN staff offered to contact patients to remind them of their appointment and if they learned of any family challenge in being able to make the appointment i.e., transportation, worked with the family on solutions. They also encouraged families to contact the dental office to cancel if they were unable to make a scheduled appointment.

The MaineCare Member Services is working with the Newborn Hearing Screening follow-up Coordinator to assist in locating current address, phone number, and physician for Moved or Gone Elsewhere (MOGO) families.

c. Plan for the Coming Year

As funding permits, we will continue to fund the Family Consultant position to optimize the delivery of services in the six Family 2 Family (F2F) Health Information Centers in Maine. This will be accomplished by building the infrastructure to support six regional family advisory councils through enhanced leadership development.

The Family Consultant will begin developing a Family Advisory Council section for the CSHN Program website.

Servicesforme, developed under the HRSA Integrated Services Initiative, allowed the CSHN program to house the Service Tapestry (a user-friendly, searchable database of resources for youth, family members, educators and service providers to locate supports and services within their area) on a temporary site at the Maine Support Network. During FY13 the program will establish a community-based section on the CSHN website and include links to these resources.

Explore the feasibility of developing a follow-up survey with families to assess whether or not the information provided through the Partners in Care Coordination was helpful, if they were able to obtain the services they needed and recommendations for improving services.

Work with MaineCare Member Services and the Maine Immunization Program's ImmPact registry to identify those children who have left their physician and no new physician is known, to attempt locating to ensure the children are up to date on their immunizations.

Continue to market the Partners in Care Coordination in provider offices to include the Patient Centered Medical Home pilot practices.

Collaborate with the District Public Health Liaisons to determine current resources available for CSHN in each district, assist districts in gaining a better understanding of the CSHN population and in identifying potential unmet needs of this population in each district.

Explore the feasibility of convening a meeting between the F2F Regions and the District Public Health Liaisons to share information specific to CSHN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	16	49	49	49	51
Annual Indicator	49	49	49	43.1	43.1
Numerator					
Denominator					
Data Source		NSCSHCN 2005/2006	NSCSHCN 2005/2006	NSCSHCN 2009/2010	NSCSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	45	46	47	48	49

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Denominator: CSHCN age 12-17 years only

Numerator: CSHCN age 12-17 years whose doctors usually/always encourage increasing responsibility for self-care and (when needed) have discussed transitioning to adult health care, changing health care needs, and how to maintain insurance coverage; CSHCN age 12-17 years old who did not achieve this outcome

Revisions and Changes: These items are the same as in the 2005/06 NS-CSHCN. These measures may be compared across years.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.

Denominator: CSHCN age 12-17 years only

Numerator: CSHCN age 12-17 years whose doctors usually/always encourage increasing responsibility for self-care and (when needed) have discussed transitioning to adult health care, changing health care needs, and how to maintain insurance coverage; CSHCN age 12-17 years old who did not achieve this outcome

Revisions and Changes: These items are the same as in the 2005/06 NS-CSHCN. These measures may be compared across years.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN Survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Due to substantial changes to this measure between the 2001 and 2005/2006 CSHCN Surveys, we have changed our objective for 2011 (when we anticipate that the next data will be available) to 51%.

a. Last Year's Accomplishments
Maine is at the forefront of helping youth with special health needs transition to adulthood. Slightly less than half (43.1%) of Maine families with a CSHN age 12-17 report their children have received services to make this transition according to data from the 2009/2010 NS-CSHCN. This is not statistically different from the 2005/2006 NS-CSHCN (49.1%) and no different than the 2009/2010 national average of 40.0%. In 2005/2006, Maine ranked 9th in the U.S. on this measure; in 2009/2010, Maine ranks 22nd on this measure.

In FY11 the youth coordinator took a fulltime position with the National Healthcare Transition Center providing technical assistance to states, facilitating monthly webinars on transition. Her departure created staffing challenges that prevented the program from making progress on this measure.

Family focused transition issues are being addressed by a Maine Parent Federation member, Beth Jones. Ms Jones has developed a "Transition Series" on such topics as employment, insurance, SSI, and housing. The sessions are held upon request by families and Ms Jones arranges for topic specific speakers to present. While there is an ongoing need in all regions of the state, human and financial resources limit the extent to which Ms. Jones is able to provide this service to families. The Maine Parent Federation reported that workshops were provided to 116 individuals on the following topics: Finding Adult Health Care Providers; Youth Leadership; and Employment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to involve youth to address issues that impact young adults.		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHN Program Director is working to identify a staff member to provide leadership to the Youth Advisory Council. However given staffing shortages and funding cuts no progress has been made.

The CSHN Director is working with program staff to review and revise the Youth Advisory Council section of the CSHN website.

c. Plan for the Coming Year

Given staffing shortages in the Program during FY13 we plan to conduct an in-depth analysis of the questions related to transition to assist us in determining if there are specific CSHN populations experiencing greater difficulty transitioning to adult health care services. Upon completion of the analysis we will focus more effort in those areas identified.

The CSHN Program will review MaineCare member materials that are sent to young adults turning 18 and will no longer be eligible for MaineCare coverage to determine other materials to be included; currently these individuals only receive a letter that explains coverage termination. The CSHN program will offer suggestions on other transition material that can be included with the MaineCare packet.

In light of continued staffing shortages, explore the feasibility of developing a transition website to house resources that families and youth can readily access.

Engage with the Coordinated School Health Program and the Maine Youth Action Network to identify potential opportunities to include CSHN youth.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	84	85	80	77	73
Annual Indicator	77.6	76.2	72.3	74.2	74.2
Numerator					
Denominator					
Data Source		National Immunization Survey 2008	National Immunization Survey 2008	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	75.5	76	76.5	77

Notes - 2011
Data are from the 2010 National Immunization Survey. 2011 survey data are not yet available; 2010 data are used as an estimate. The estimate is based on the 4:3:1:3:3 vaccination series.

This definition includes 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib), and 3 or more doses of Hepatitis B vaccine.

Notes - 2010
Data are from the 2010 National Immunization Survey. The estimate is based on the 4:3:1:3:3 vaccination series. This definition includes 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib), and 3 or more doses of Hepatitis B vaccine.

Notes - 2009
Data are from the 2009 National Immunization Survey. Estimates are based on children who received the 4:3:1:0:3:1 vaccine series which is 4:3:1 plus 3 or more doses of HepB vaccine, 1 or more doses of varicella vaccine, and 4 or more doses of PCV. Hib vaccine is excluded.

Data on 4:3:1:3:3 are not presented in the NIS estimates for 2009. Maine's 4:3:1:0:3:1 2008 estimate is 73.1.

a. Last Year's Accomplishments
Maine's childhood immunization data are obtained from the National Immunization Survey (NIS), a continuing nationwide sample survey conducted among families with children 19-35 months of age and their healthcare providers.

Due to a shortage of Hib vaccine in 2008 and the methods of reporting Hib, CDC changed the NIS reporting of 4:3:1:3:3 vaccine series in their tables. However, a version of the 4:3:1:3:3 comparable to prior years was provided by the CDC and approved by HRSA. According to this version of NIS data, Maine's immunization rates for 19-35 month olds, based on the 4:3:1:3:3 was 74.2%. The 2009 estimate for this series was 72.3%. In 1997, Maine's 4:3:1:3:3 immunization rate of 78.4% was the second highest in the country. Today, only 14 states have worse immunization rates.

L.D. 1408, "An Act to Establish the Universal Childhood Immunization Program" created a system of universal vaccination in which all children (0-18 years), regardless of health insurance coverage, have access to the vaccinations they need. The bill also established the Maine Vaccine Board a true public-private partnership. The Board works with the Maine Immunization Program (MIP) in setting policy, purchasing and distributing vaccine, and billing insurance companies for their share of the vaccine cost (based on the number of covered children).

This eight member board, appointed by the Governor, is comprised of three providers, two state Medical Association representatives, one community public health representative and two pharmaceutical representatives. The MIP worked with the Vaccine Board to provide background information on vaccine funding mechanisms, vaccine management requirements, and vaccine distribution. The board makes determinations on vaccines to be included in Maine's vaccine supply. (For FY12 all ACIP recommended childhood vaccines are included.)

MIP recruitment efforts during FY11 resulted in approximately 480 providers participating in the web-based electronic reporting system, ImmPact. Those not participating (3-4 family practices) are in rural areas of the state that do not have internet access. The MIP allowed them to fax vaccine requests to the program and the vaccine was sent to the provider. Of those participating, approximately 50% are fully integrated; that is they provide individual vaccination data (vaccines received by each child in their practice). The remaining 50% are aggregated in that providers submit the total number of vaccinations administered per month.

The MIP worked with Policy Studies, Inc. (PSI) to undertake a study to further explore and quantify why some Maine families are hesitant to vaccinate their children. Based on study findings, PSI developed an Immunization Outreach Education ToolKit to promote immunization among Maine Parents. The Full Report (Parents' Immunization Hesitancies in Maine and Social Marketing Strategies to Overcome Them) and Toolkit can be found at: https://www.maine.gov/dhhs/mecdc/infectious-disease/immunization/providers/index.shtml

During FY11, Maine began planning and recruitment of participating practices for its EPSDT/Bright Futures Learning Initiative, called First STEPS (Strengthening Together Early Preventive Services). First Steps is a comprehensive effort to provide outreach, education, and quality improvement support to primary care practices to improve EPSDT rates.

93.1% of enrolled children in the Maine Families Home Visiting Program (MFHV) during FY11

were up to date on immunizations; overall 2,407 children were served by MFHV. Immunization is embedded in the curriculum of home visitors and is a performance measure for the contracted community agencies. As they become aware of barriers families encounter (i.e. transportation) and assist with working through them, the home visitors record the data and share it with the MIP. Home visitors talk with parents about their specific concerns and risks and encourage them to talk with their doctor about immunization.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and guidance regarding best practice and quality assurance/improvement.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY12 the MIP disseminated the Immunization Outreach Education Toolkit to Public Health District and Tribal Liaisons, Maine Health and Maine Primary Care Association for use in approaching parents regarding immunization. An important feature of the toolkit is the messaging strategies that were developed specific to regions of the state; a one size fits all approach was not considered as Maine's population is diverse and was recognized as an important component in developing the social marketing campaign.

In December the MIP administered its' annual Point in Time Survey with elementary and middle schools, colleges, daycare and health facilities to assess immunization rates. A primary focus of the survey in schools is the exemption rates. In school years 2010/11 and 2011/12, the exemption rates were 3.8% and 3.7% respectively. In 2011/12, about 89% of exemptions were philosophical, 2.5% religious and 8.8% were medical.

The MIP continues to work with providers to promote electronic data exchange. Provider concerns around security present a challenge for the program however one on one recruitment efforts remain a priority.

Between September 2011 and February 2012, Maine completed Phase One of First STEPS that focused on raising immunization rates and implementing primary care practice office system changes advocated by the AAP Bright Futures. There were 25 practices enrolled in Phase One. These practices serve over 30,000 children insured through MaineCare.

c. Plan for the Coming Year

Maine's Title V program will continue to monitor NIS data in relation to the new vaccine reporting.

The federal CDC is piloting their national centralized electronic vaccine distribution system. This system, called VTrckS, will replace the current technology. Implementation of this new system will allow for more efficiently managing the distribution and monitoring of vaccines. This system will

interface with Maine's ImmPact system and provide for enhanced vaccine management. Maine anticipates being on board in April 2013.

Public Health Nursing and Community Health Nursing (PHN/CHN) work with families referred to the program for an identified health need; services provided are for a limited time. Referrals of families with newborns are often within one to two months of birth, which is prior to the first immunizations. While under PHN/CHN care, the family immunization status is checked. Families are provided with schedules and immunization education during visits. At the point of discharge PHN/CHN refer those families still requiring support to Maine Families Home Visiting; this ensures a timely follow-up on appropriate childhood immunizations.

The MIP will work to identify additional mechanisms to further disseminate the "Immunization Outreach Education Toolkit". The Maine Families Home Visiting Program will promote the Toolkit by directing home visiting sites to the MIP website to download the Toolkit.

MIP will continue to work with the Early Childhood Director, Early Childhood Comprehensive Systems Initiative, and Maine Families Home Visiting Program to identify ways to link their respective databases and share data in an effort to provide a more complete picture of the immunization of Maine residents.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9.6	9	10	9.7	8.2
Annual Indicator	9.4	10.3	9.9	8.3	9.3
Numerator	251	268	248	208	225
Denominator	26825	26003	25037	25047	24316
Data Source		Birth certificates, Maine Vital Statistics Office	Birth certificates, Maine Vital Statistics Office	Birth certificates, Maine Vital Statistics Office	Birth certificates, Maine Vital Statistics Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	9	8.8	8.6	8.4	8.2

Notes - 2011
2011 birth rate per 1,000 female population 15-17 is provisional and subject to revision. Birth data are from the Maine Office of Data, Research and Vital Statistics. Population estimates are from the US Bureau of the Census as of July 1, 2011.

Notes - 2010
Birth data are from the Maine Office of Data, Research and Vital Statistics. Population estimates are from the US Bureau of the Census as of July 1, 2010.

Notes - 2009
Birth data are from the Maine Office of Data, Research and Vital Statistics. 2009 population estimates are from the US Bureau of the Census as of July 1, 2009.

a. Last Year's Accomplishments
Between 1990 and 2003 Maine's adolescent pregnancy rate declined steadily and consistently. In recent years, this rate of decline has diminished and there has been more variation in the rates over time. However, Maine's adolescent birth rate among 15-17 year olds has declined 33% between 1997-01 and 2007-11. In 2011, Maine's rate of births among 15-17 year olds was 9.3 per 1,000. Between 2007 and 2011, Maine averaged 240 births to 15-17 year olds each year; in 2010 there were 208 teen births and in 2011 there were 225 teen births. These numbers are the lowest the state has ever seen. Maine met its Healthy Maine 2010 objective on this indicator of 13.6 per 1000 females. According to a 2012 National Center for Health Statistics Brief (#89), 47 states experienced declines in their birth rates among adolescents aged 15-19 years between 2007 and 2010. Maine was one of 16 states that experienced at least a 20% decline over this time period. Maine's adolescent birth rate has consistently been lower than the U.S. rate.

Data from the 2011 Maine Integrated Youth Health Survey (MIYHS) reveal that 45% of high school students in Maine have ever had sexual intercourse. Among 12th graders, 64% have had sex; among 9th graders, 25% reported having had sex. The % of high school students reporting ever having sex has not changed substantially over the past few years (42.4% in 2007; 45.1% in 2009), but the % who report using a condom at last intercourse has increased since 1995 from 46.9% to 63.9% in 2011, and oral contraceptive use remains relatively high at 36.3% among females, revealing the importance of family planning to lowering Maine's teen birth rates.

Maine is committed to keeping our teen birth rate low through its work with Family Planning (FP) clinics, ongoing data monitoring, and with educational programming. FP clinics served 27,127 clients including 6,794 teens in FY11. Eight schools or community-based organizations implemented evidence-based programs to prevent teen pregnancies and HIV/STI.

The Annual Comprehensive Sexuality Education Conference was held in April 2011. The conference is intended for school administrators, health educators and community leaders working with youth, to provide updates and education on adolescent sexual health issues. Pam Wilson, a MSW with many years of experience working with youth and parents, was the keynote speaker. She is also featured in the sexuality education video; Raising Healthy Kids: Families Talk About Sexual Health; designed for parents and discusses when to begin talking with your child about sexuality. The theme of the conference was "Don't Forget the Music"; 142 participated in the conference. This is a continuation of a collaborative effort between the Teen and Young Adult Health Program, Family Planning Association (FPA), Department of Education (DOE), University of Maine at Farmington, New Beginnings of Lewiston and the Maine HIV/STD Program.

The Maine CDC received funding from the Family Violence Prevention Fund to implement Project Connect. One of two project goals is to partner with School Administrative Units to develop policy

and protocol responses to domestic violence, sexual violence, and reproductive coercion affecting adolescents. (See State Performance Measure # 2 for more details on Project Connect)

The LD 1105 Teen Dating Violence Prevention Workgroup drafted a model school policy with input from Project Connect pilot schools and the Maine School Management Association (MSMA). As of the submission of this report the policy had not yet been sanctioned by the Maine Principal's Association or the MSMA.

The DOE added an HIV prevention component to its' Key Concepts document, a tool that links key concepts in health areas such as family life education, sexual assault prevention, and alcohol and other drug use prevention to the health education standards and performance indicators outlined in the 2007 Maine Learning Results. It is promoted to health educators, school health coordinators, curriculum coordinators and other school personnel to support pregnancy prevention, disease prevention, and healthy sexuality.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family planning clinical services.	X			X
2. Community-based pregnancy prevention using evidence-based programs.		X	X	X
3. School-based Health Center base funding, technical assistance and standards implementation.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Hiring freezes and elimination of some positions challenged the ability to hire a fulltime Adolescent Health Coordinator. One of the outcomes of the restructure of the Maine CDC and the distribution of programs within the former Division of Family Health has been the opportunity to link programs that are working with similar populations. This is fortuitous in the area of adolescent health as the funding for the US CDC Coordinated School Health Program (CSHP) is being phased out and is expected to end in 2013. The Maine CDC CSHP staff person, who has previous experience in adolescent health, will become the Adolescent and School Health Coordinator (ASHC). The ASHC will work with other Division of Population Health (DPH), Maine CDC and Department programs on adolescent health issues such as; obesity prevention, reproductive health and access to health services.

c. Plan for the Coming Year

The FPA of Maine is facing both federal and state funding cuts that will significantly impact their overall budget. If the cuts are implemented FPA will have to close clinics. Such a move will create access concerns, particularly for teens if they have to travel long distances to obtain confidential services.

The Maine DOE will promote the Health Education Key Concepts curriculum development tool to health educators, school health coordinators and other school personnel which support pregnancy prevention, disease prevention, and healthy sexuality education. DOE will continue to

engage Project Connect Pilot Schools in future activities of the initiative. Planning is underway to launch a website that will house resources for both students and teachers.

Maine's 2011 adolescent birth rate was slightly higher than the 2010 rate, but remained lower than rates over the past 15 years. We anticipate that Maine will continue to show progress on reducing the rate of births to teens. Our objectives for the next five years reflect ongoing improvement. Although our objective is consistent with trends in recent years, budget cuts to services such as family planning may make achieving this objective challenging.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	60	60	59	60
Annual Indicator	56.6	56.6	58.9	58.9	68.5
Numerator	636	636	208	208	
Denominator	1123	1123	353	353	
Data Source		Maine Child Health Survey	Maine Integrated Youth Health Survey	Maine Integrated Youth Health Survey	Maine Integrated Youth Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	68.5	69	69	69.5	69.5

Notes - 2011
Data for this measure come from the oral health screenings conducted as part of the 2011 Maine Integrated Youth Health Survey (MIYHS)--kindergarten/third grade version.

Data are weighted so the numerator and denominator are not presented.

Weighted Numerator=7,747

Notes - 2010
Data for this measure come from the oral health screenings conducted as part of the 2009 Maine Integrated Youth Health Survey (MIYHS)--kindergarten/third grade version. The response rate of

the k/3 MIYHS was 31%, so the data were not weighted. This may limit the generalizability of the data to the entire population of third graders in the state.

Notes - 2009
Data for this measure come from the oral health screenings conducted as part of the 2009 Maine Integrated Youth Health Survey (MIYHS)--kindergarten/third grade version. The response rate of the k/3 MIYHS was 31%, so the data were not weighted. This may limit the generalizability of the data to the entire population of third graders in the state.

Parent report of dental sealants was also collected as part of the k/3 MIYHS--73% of parents who were surveyed reported that their third grade ever had sealants.

a. Last Year's Accomplishments
Maine uses data from the kindergarten/3rd grade Maine Integrated Youth Health Survey (MIYHS) to report this measure. In 2011, 68.5% of 3rd graders had a sealant on at least one permanent molar tooth, showing an increase over the past decade. This is the first year that the kindergarten/3rd grade version of the MIYHS had a response rate over 60% allowing us to weight the data, and feel confident about its generalizability. The higher response rate is attributable in part to the schools that participated in the previous MIYHS. They and school nurses were champions for schools participating in the survey for the first time. The Oral Health Program (OHP) Public Health Educator (PHE) worked with DOE's School Nurse Consultant to train nurses, obtain CE credits, and provided stadiometers, toothbrushes and disposable mirrors. These incentives helped with participation.

Within funding limits, the OHP maintains the dental sealant component of its School Oral Health Program (SOHP) that also supports classroom education and fluoride mouthrinse programs. In SFY11, sealants were provided in 96 schools; 868 2nd grade students received 2876 sealants (average of 3.3 sealants each), and 92 3rd graders received 264 sealants. Funding remained in focus with additional limitations because of a reduction in Fund for a Healthy Maine funding to the OHP, following the previous year's redirection of state General Fund support. Continued attention was given to program requirements to assure that funding went to schools where children can be expected to have greater oral health needs and less regular access to care. As a result, a few schools were dropped from the SOHP.

A major accomplishment was that the two largest school-based programs (Aroostook and Washington Counties with 28 and 31 schools respectively) began to bill MaineCare for sealants, fluoride varnish applications and oral health education. Billing is critical in moving these programs toward sustainability. Both counties have high uninsured rates so this income will assist them in covering the cost of services. The PHE provided technical assistance to the programs to link them with MaineCare provider relations staff, connected weekly by phone or email to provide necessary support; worked with MaineCare staff to determine the correct CDT codes for proper billing; changed forms to be HIPAA compliant; and facilitated MaineCare staff traveling to the two counties to train the school program staff on billing for these services.

The consolidation and re-structuring of school districts creates a challenge in managing the sealant program. For example, schools plan to participate but then later withdraw because they break away from a newly formed School Administrative Unit (SAU); or they aren't planning or funded to participate but then became a part of a participating SAU and want to join the program. School reorganization is also a factor in the reduced number of schools with sealant programs compared to previous years.

The OHP continued its work pursuant to the 5-year State-Based Oral Disease Prevention Program Cooperative Agreement from the CDC (started 7/31/08). The activities of this grant support refinement of the OHP's school-based programs, particularly the sealant component. The data collection/cost analysis tool provided by CDC did not work for us, with many small rural schools. With new Epidemiology staff, developing a Maine-based tool was to be a priority, as was

finalizing a burden of disease report. Both projects were to be completed during SFY12.

The OHP's PHE developed and delivered the annual meeting for local SOHP coordinators in four locations, including administrative updates and a presentation on childhood oral pathology.

The OHP's MCHB grant under the Targeted Oral Health Service Systems program [Kids Oral Health Partnership (www.kohp.org)] ended August 31, 2011. It increased the number of young children who received oral health assessments and preventive dental visits and were identified as having a dental home, by implementing outreach and training activities and developing relationships with local agencies (e.g., Head Start and child care provider groups) and provided training to child care and medical care providers. With the Maine Dental Access Coalition, KOHP hosted a well-received conference in May 2011 with national speakers on early interventions and children's oral health. Final reports on KOHP will be posted to the OHP website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain the number of schools with sealant programs.	X		X	
2. Implement database or other tool for sealant program data collection and school oral health program.		X		X
3. Determine efficacy of resuming billing as MaineCare provider for sealants and or seek other supplementary funding.				X
4. Collaborate on continuing refinement and implementation of the Maine Integrated Youth Health Survey (includes an oral health component).			X	
5. Coordinate process of updating the State Oral Health Improvement Plan.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

School eligibility for the OHP-coordinated SOHP is based on the proportion of students eligible for Free and Reduced Lunch and the extent of fluoridated public water as primary factors; it is thus directed to schools where children have greater oral health needs and less regular access to care.

Implementation of the US CDC's data collection tool, intended to help evaluate the effectiveness and efficiency of school sealant programs, did not account for rural care, often more costly to deliver than in larger urban areas, and inflated the cost of delivering school-based sealants. We and several other states were given permission by CDC to develop our own database to better reflect our situation. Maine has a very high sealant retention rate (84-97%). To maintain this, the OHP's Public Health Educator provided three month retention checks for new providers applying sealants to ensure they were being done properly. In many schools in FY11 fluoride varnish application was provided along with sealants.

In this biennium, state funding for the SOHP was cut by $325,000 and a 32% reduction in the FHM for SFY 12 meant that we reduced or used funding meant for other oral health programs and reduced the fluoride mouthrinse component while we continue to review and refine program standards.

The OHP is engaged in workforce development activities with HRSA/BHP support. We support water fluoridation activities; recent activity has been to counter challenges to fluoridation.

c. Plan for the Coming Year
We will keep the objective for this measure at 60%; the 2011 MIYHS indicates that 68.5% of 3rd graders have at least one sealant, comparing well with Healthy People objectives. Continuing concerns about costs and access to care could influence this accomplishment.

The state budget for SFY13 reduced the OHP's $600,000 from the FHM to $300,000. We were directed to split the funds between the SOHP and a program that subsidizes care for uninsured adults at community dental clinics. This threatens the sustainability of both initiatives. OHP will continue the SOHP and dental sealant program, focusing on quality improvement and program efficiency. To fund schools and sealant components, more adjustments were made; funding for fluoride mouthrinse will depend on the availability of one-time funds from the Preventive Health and Health Services Block Grant.

The role of "district oral health coordinators," piloted in FY11 and evaluated in FY12, will be further developed within available funds. The OHP's PHE will conduct trainings with schools for using the new database. They will submit data via CD. Training will begin in fall 2012 with data collection during SFY13. The PHE will monitor new providers on a quarterly basis to assure quality and the high sealant retention rate.

A training, "Assuring Quality in School Sealant Programs," was held June 1, 2012 in collaboration with the Maine Dental Access Coalition. It featured national speakers and was geared for dental hygienists working with school sealant programs, their supervising dentists and dental clinics and practices that may serve as referral sources for schools. Follow-up on issues raised is expected in SFY13.

A proposed school entrance oral health screening program, first funded during the 2006 legislative session, was not implemented. 2009 legislative action directed the OHP to implement up to three pilot programs and report back in 2010. The report was not completed, but has been called for by August 1st. We may be directed to implement a dedicated program in SFY13. As noted above, funding for screening was diverted to support the SOHP and the district coordinators. We will be challenged to support all three efforts.

Our Oral Health Improvement Plan revision process started in March 2011 with a broad range of stakeholders but was set aside due to other priorities. We will work during SFY13 to complete it. With our epidemiologists, we will implement our oral health surveillance plan. The CDC grant, which fully supports the OHP's two professional positions, ends in July 2013 with a new competition expected in the late winter for another 5-year cycle. Within funding constraints, the OHP will support the Maine Dental Access Coalition, a broad-based stakeholder group. Several CDC grant activities involve the Coalition, including promoting collaborations that support school-based oral health education and sealant programs, community water fluoridation, and program integration and collaboration.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	3	3.2	3.1	2.5	2
Annual Indicator	3.2	2.6	2.1	1.8	1.8
Numerator	36	29	23	20	20
Denominator	1126269	1118193	1111447	1112387	1112387
Data Source		Death certificates, Maine Vital Statistics Office	Death certificates	Death certificates	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.7	1.6	1.5	1.4	1.3

Notes - 2011
Data from 2011 death certificate data are not yet available. 2010 data were used as an estimate.

Notes - 2010
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Data are from the Maine Office of Data, Research and Vital Statistics. Denominator data are based on estimates as of July 1, 2010 from the US Census Bureau.

The 2010 indicator is the 5-year average for 2006-2010. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819.

Notes - 2009
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Data are from the Maine Office of Data, Research and Vital Statistics.

The 2009 indicator is the 5-year average for 2005-2009. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819.

a. Last Year's Accomplishments

Motor vehicle crashes are the leading cause of death among children age 1-14 years in Maine. Maine's 5-year average rate of motor vehicle deaths among children age 14 and younger for 2006-2010 was 1.8 per 100,000 children. This is the lowest 5-year average rate Maine has experienced dating back to 1992-1996 and continues the declining trend in this measure. Maine's rate has generally been lower than the U.S. rate over time but this difference is not statistically significant. Based on 2011 MIYHS data, only 5.1% of middle school students reported "never" or "rarely" wearing a seatbelt when riding in a car. This is a significant decline from 10 years ago when more than 1 in 4 middle school students (26.5%) reported never or rarely wearing a seatbelt. Data from Maine's 2008 Pregnancy Risk Assessment Monitoring System reveal that almost all new mothers (98.8%) report that their infants always ride in an infant car seat and this seat is located in the back seat of the vehicle (99.6%). Data on Maine's motor vehicle death and injury rates led the Maine Injury Prevention Program (MIPP) to identify motor vehicle traffic crashes as a priority in their program plan.

In January 2009, the Bureau of Highway Safety (BHS) assumed statewide responsibility of ordering and distributing child passenger safety seats to all Child Passenger Safety (CPS) sites and fitting stations. This change has impacted the ready availability of data on the number and types of seats distributed that was previously maintained by the MIPP. The Child Passenger Safety Advisory Council was disbanded and was reconvened as the Child Passenger Safety Steering Committee. The MIPP has expressed an interest to the BHS to participate on the Committee but has not yet received an invitation.

Maine's Home Visiting Program conducts safety assessments every six months and provides information to families related to car safety. Families are encouraged to have their car seats checked by a certified car seat installer. The assessment covers four areas: children are never left alone in the car; a child safety seat is placed in the back seat facing in the appropriate direction for age and weight; a child safety seat is used on every ride; and caregivers buckle up on every ride.

In February 2011, the MIPP participated in a BHS National Transportation Safety (NTS) Committee audit for assessment of CPS inspection and distribution sites. The assessment brought together technicians and instructors from across the state to identify strategies to strengthen and support the work of CPS.

In 2011, the MIPP provided data to the American Automobile Association and other transportation safety advocates to use in their education of the legislature about LD 64 "An Act to Make a Violation of the Laws Governing Seat Belts" a Secondary Offense. The bill did not pass so violation of the seatbelt law remains a primary offense.

The MIPP hosted its last CPS training meeting in September 2010 for technicians and instructors to provide updates on technology, recalls, and hands-on activities involving the various safety seats used by the CPS sites, and to provide networking opportunities.

The Department of Education (DOE) updated its Health Education Key Concepts curriculum development document to include injury prevention. MIPP and the Maine Department of Transportation provided expert input into this newly developed section. Motor vehicle safety is a major component of injury prevention with several concepts having a direct link to motor vehicle safety.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Assist in planning and implementation of a tri-state transportation safety conference - Maine/NH/VT.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MIPP provides data and information on preventing injuries at home and other settings to the Tall Pine Safety Resource Center, the lead agency for Safe Kids Maine, upon request. The Center provides outreach and safety information to the public to prevent unintentional injury.

The DOE includes injury prevention in its Key Concepts curriculum development tool. Motor vehicle safety is a major component of injury prevention with several concepts having a direct link to motor vehicle safety. The DOE distributes injury prevention materials to health education teachers and wellness team leaders and provides professional development on the implementation of the Key Concepts documents.

c. Plan for the Coming Year
The objectives for this measure anticipate continued improvement in this measure over time.

While the MIPP's role in child passenger safety is more limited than in the past, the program will continue to: Manage statewide CPS program resources; Increase public awareness of CPS program resources in Maine by providing resources and support to CPS professionals in Maine enabling them to sustain their volunteer child passenger safety work; Assist in raising awareness of the availability of seats to families in need including those with special needs; Provide educational materials and resources on CPS to professionals, advocates and the general public upon request; Continue work on its program website for dissemination of prevention information including prevention resource contacts, data, training opportunities and links to other Maine and national injury prevention resources; Coordinate activities with Safe Kids Maine in promoting CPS; Continue to participate on Maine Transportation Safety Coalition and other CPS related committees and councils; Provide a link on the MIPP website to the BHS for CPS; and, Assist in the planning and implementation of a statewide injury prevention conference.

DOE will continue to distribute the Health Education Key Concepts curriculum development document, provide professional development in using the tool and participate in programming with the MIPP and Coordinated School Health Program.

Partnerships will be expanded with the Department of Transportation Safe Routes to Schools Program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective	2007	2008	2009	2010	2011

and Performance Data					
Annual Performance Objective	41	47	44	46	48.5
Annual Indicator	46.1	43.3	42.8	48.2	48.2
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	49	49.5	50	50.5	51

Notes - 2011
Data for the 2011 indicator are based on the National Immunization Survey and represent provisional data for Maine's 2007 birth cohort. Updated data for this indicator have not yet been released, but are anticipated in 2012.

Notes - 2010
Data for the 2010 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2010 indicator represents provisional data on the percent of children in Maine, born in 2007, who were breastfed for 6 months. Data for this indicator should be finalized in 2012.

Notes - 2009
Data for the 2009 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2009 indicator represents the percent of children in Maine, born in 2006, who were breastfed for 6 months. Data from the 2007,2008 and 2009 surveys were combined to obtain this estimate.

a. Last Year's Accomplishments
The CDC Pregnancy Risk Assessment and Monitoring System (PRAMS), the Maine Newborn Breastfeeding Surveillance System (breastfeeding rates at hospital discharge), and the National Immunization Survey (NIS) include Maine breastfeeding data. Maine has chosen to use the NIS because it is the only data source that is generalizable to all women in Maine and includes

women who are at least 6 months postpartum.

The NIS now presents breastfeeding information according to the child's year of birth, rather than the year the respondent was interviewed. Due to NIS changes to data presentation, the most recent data available for this measure are based on children born in 2007. According to these data, 48.2% of children born in Maine in 2007 were breastfed for at least 6 months and 18.2% were exclusively breastfed for 6 months. These percentages are higher than the national average, but not statistically higher; Maine ranks 19th in the U.S. on this measure. According to the NIS, 75.2% of Maine children born in 2007 were ever breastfed. Based on Maine PRAMS data 79.9% of Maine mothers in 2009 and 83.2 in 2010 initiated breastfeeding; 56.1% were still breastfeeding when they completed the survey in 2009 and 55.8% in 2010, which is usually when their infants are about 3 months old.

Programs in Maine focused on improving breastfeeding rates among new mothers are: WIC, Maine Families Home Visiting (MFHV) and Public Health Nursing (PHN).

Some local WIC agencies have had approximately 30% of their infants being exclusively breastfed. However during the latter part of FY11 the WIC program saw a drop in the rates. The program attributes this decrease to a couple of factors. Funding cuts have resulted in local agency staffing shortages that increased the ratio of staff to clients and staff expressed concern at not having sufficient time to discuss breastfeeding at client visits. The program also had a change with the infant formula contract, changing from Nestle (Good Start infant formulas) to Mead Johnson (Enfamil infant formulas); there are anecdotal reports that breastfeeding promotion may be impacted by this change based on a more favorable perception of Enfamil products by health care providers, thus leading to earlier introduction of infant formula.

The State WIC Agency tested a new brand of electric breast pump, Hygeia, for user acceptance. The purpose was to obtain participant feedback on the pump, and if favorable, purchase a supply of pumps for each local office in order to increase the number of loaner electric breast pumps available. Based on the positive feedback from clients, the increased number of exclusively breastfeeding women (from 24% to 30%), as well as the increased demand for breast pumps, the WIC program purchased 150 breast pumps. Purchasing such a large number resulted in a significant decrease in the per unit cost.

There are eight breastfeeding peer counselors in six local WIC agencies. Peer counselors are mothers who have previously breastfed, are enthusiastic about breastfeeding and are trained to offer encouragement, information and support to mothers enrolled in WIC.

MFHV actively encourages new mothers to breastfeed, provides support and information and links mothers to resources such as hospital breastfeeding classes and lactation consultants. MFHV has lactation counselors embedded in several sites. In FY11 the percentage of breastfeeding dyads met or exceeded goals with 75% initiating breastfeeding and 26% breastfeeding at 12 months. The percentage breastfeeding at six months continues to be a challenge with only 35% breastfeeding at this point. Home visitors ask about breastfeeding duration and type (exclusive or with supplements) at every visit while each child is still breastfed.

Referrals from WIC to MFHV rose from previous years indicating some growth in communication and partnering which should support better outcomes for families being dually served by these programs.

Due to both the geography of the state and limited PHN staff, PHN contracts with five Community Health Nursing (CHN) agencies to provide home health nursing services to mothers and children in specified portions of the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate available data sources and improve the accuracy of WIC breastfeeding data with implementation of the new data system.				X
2. As funding permits offer training opportunities for WIC counselors, public health nurses, and home visitors on the development of counseling and clinical skills to support optimal breastfeeding practices.				X
3. Enhance the WIC breastfeeding peer counselor program.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maine CDC WIC Breastfeeding Coordinator and five WIC local agency staff successfully completed the exam to become International Board Certified Lactation Consultants (IBCLC).

The WIC Program is transitioning to a new data collection system, Successful Partners in Reaching Innovative Technology (SPIRIT), that will have more accurate breastfeeding data in future years. A number of new data fields are being added related to breastfeeding to track eating patterns and introduction of solid foods.

The WIC program is collaborating with the state Physical Activity Nutrition and Healthy Weight Program, PHN, Early Head Start Program and Maine Infant Toddler Initiative to form a Breastfeeding Stakeholder Group to focus on educating child care providers on breastfeeding. The Breastfeeding Stakeholder Group is working with the Resource Development Centers to develop an online curriculum to train child care providers on breastfeeding basics and support for breastfeeding infant/mother dyads; i.e. benefits, milk storage, and normal feeding behaviors and patterns. The group is also working with a publishing company that creates breastfeeding books to make available sample packets of breastfeeding books to child care providers and is developing a checklist for child care providers on how to become a 'Baby Friendly' child care provider; i.e. availability of private and clean space for mom to pump, availability of refrigerator to store breast milk. (Copy attached)

An attachment is included in this section. IVC_NPM11_Current Activities

c. Plan for the Coming Year

Based on the estimates available, our objectives have remained the same; we hope to increase our breastfeeding at six-month rates by at least 1% each year.

The WIC Program will focus on attaining two goals: 1) Maine CDC WIC participants will have improved health and well-being through access to quality WIC nutrition services; and 2) the Maine CDC WIC Nutrition Program will provide effective, efficient and culturally sensitive services to all WIC participants.

Expansion of the Breastfeeding Peer Counselor Program to a total of six local agencies (previously five agencies) will assist the WIC Program to address the goal of increasing the number of WIC mothers who are breastfeeding their babies at six months. Budget cuts have

prevented the program from taking on any new initiatives; however, as funding permits, breastfeeding educational opportunities will be provided.

The State WIC Agency will continue to collaborate with local WIC agencies and the Maine State Breastfeeding Coalition to enhance breastfeeding promotion and support strategies.

The MFHV Program will continue efforts to increase prenatal enrollment and work with WIC to help reinforce messages on breastfeeding.

PHN is working on improving their data system to track improvements in client outcomes, such as breastfeeding initiation and duration.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	96.5	96.8	97	97.1	97.9
Annual Indicator	97.1	96.1	97.8	96.0	96.0
Numerator	13560	12974	13054	12304	12304
Denominator	13969	13500	13353	12810	12810
Data Source		Maine Newborn Hearing Program	Maine Newborn Hearing Program	Maine Newborn Hearing Program	Maine Newborn Hearing Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	96.2	96.4	96.6	96.8	97

Notes - 2011
2011 data are not yet available. 2010 data are used as an estimate.

Notes - 2010
The 2010 data are from the Maine Newborn Hearing Program as of February 6, 2012.

The numerator is the number of infants who were screened for hearing loss by 1 month of age.

The denominator is the number of occurrent births in Maine in 2010.

Notes - 2009
The 2009 data were available from the Maine Newborn Hearing Program as of December 31, 2010.

MNHP does not maintain data on those who are screened prior to discharge from a birth facility, only screened/passed/refer by age. Therefore, the numerator for this indicator reflects infants screened by 1 month of age, the closest proxy we have to screening at discharge. Estimates include all hospitals.

The denominator is the number of occurrent births in Maine in 2009.

a. Last Year's Accomplishments
The Maine CDC Newborn Hearing Program (MNHP) was established in 1999. Since January 2003, every birthing facility has been required to report to the MNHP the number of babies born in their facility, the number of newborns who received a hearing screen, the result of the hearing screen and the number of newborns whose parents declined hearing screening.

An electronic data tracking system, ChildLINK, links newborn hearing screening data with the electronic birth certificate, enabling the MNHP to verify that every baby born in Maine has a newborn hearing screen and to track follow-up services regarding audiological evaluations and referrals to and participation in early intervention services. Birthing facilities and audiologists have the capability of submitting screening and diagnostic data via this web-based system.

Data submitted to ChildLINK during CY10 indicated 12,810 births occurred in Maine with 12,502 (98%) screened for hearing loss. Of these, 12,304 (98%) were screened by 1 month of age. Of the 310 babies not screened, 54 expired prior to having the hearing screen, 27 were not screened due to parent refusal and 229 were missed. Of the 229 who were not screened/missed, 177 of these were home births. The remaining 52 babies were missed due to being transferred to an out-of-state facility, moved out-of-state, medically unable to screen, or the hospital screener was broken and the family did not return for out-patient screening.

Of the 12,502 screened, 194 (2%) did not pass the screening. To date we have received 131 (68%) reports on those referred to an audiologist with 94 (71%) having their diagnosis complete by 3 months of age. Of the 131 reports, 17 were identified with hearing loss. Of the 63 without a known diagnosis, 7 moved out-of-state, 8 families refused follow-up, 16 families were unresponsive (contacted many times but did not keep audiology appointments), 11 families were unable to be contacted (phone number not in service, address unknown and 21 were lost to follow-up). In addition, we received reports on 6 children who either passed their newborn hearing screen or were not screened at birth who were diagnosed with a hearing loss.

We have received reports that 6 (35%) children who referred on their hearing screen and were diagnosed with hearing loss have Individual Family Service Plans with Child Development Services (CDS), our Part C provider in Maine. The NBHP was unable to report whether or not the remaining 11 children were determined to be eligible for services through the State's Part C System due to the Family Educational and Privacy Act (FERPA) which prevents the Part C System from notifying the NBHP of a child's eligibility without written consent of the parent/guardian. The NBHP is working with the Part C System to have the NBHP added to the consent form.

In CY 2010, a hearing screening program was established within a midwifery practice that attends approximately 35-45 home births per year. To date the MNHP has seen an increase in our screen rates for home births. In CY2009, 12% of home births were screened while in CY2010, 16.4% were screened and preliminary data for CY2011 shows that 20% of home births were screened.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor compliance of hospitals and audiologists reporting via the electronic reporting system.				X
2. Create a hearing screening training module for birthing facilities.				X
3. Provide tracking of newborns who do not pass the hospital screen.				X
4. Develop protocols and procedures to improve data entry and tracking of children with risk factors for late onset hearing loss.				X
5. Continue to educate providers about the mandated requirement of providing results of audiological evaluations to the Newborn Hearing Program.				X
6. Collaborate with Child Development Services, Part C agency to facilitate referrals into early intervention.		X		
7. Continue to facilitate the Newborn Hearing Program Advisory Board.				X
8. Create an educational brochure on hearing screening to be provided to prenatal classes as well as health care providers who offer obstetric services.				X
9. Work with Maine midwives to improve access to newborn hearing screening for those children born at home.				X
10.				

b. Current Activities

Fiscal constraints prevented the program from carrying out any new activities during the current year. The program continues to work to ensure that all babies are screened and follow-up with families and primary care providers to ensure that babies who refer on their hearing screen have a complete audiological diagnostic evaluation completed, and those babies who are confirmed to have hearing loss are referred to Part C.

c. Plan for the Coming Year

During FY13, MNHP plans to continue to implement and monitor quality assurance and quality improvement plans in the management of a statewide universal newborn hearing system, improve audiology reporting and access to early intervention services.

In the coming year, data from Maine's ChildLINK system for infants in the selected birth cohort will be used to identify infants who did not pass their newborn hearing screen and determine their audiologic evaluation status. Google maps will be used to obtain the latitude and longitude coordinates for audiology facilities that have the capacity to evaluate infants and SAS will be used to calculate driving distance from mother's town of residence to nearest audiology facility. A map will be created showing the geospatial distribution of children who did not pass their newborn hearing screen and the locations of audiology facilities and analyses will be conducted examining the association between driving distance and time to nearest audiology facility and audiologic evaluation status (i.e., whether infant saw an audiologist, whether audiologic evaluation was completed, and whether audiologic evaluation was completed by 3 months of age). A report will be written that will describe project rationale, methodology, results and recommendations.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.5	8	5.6	5.4	4.9
Annual Indicator	5.6	5.5	5	5	5
Numerator					
Denominator					
Data Source		Current Population Survey 2006-2007	Current Population Survey	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.9	4.8	4.8	4.7	4.7

Notes - 2011
2011 data for this indicator are not yet available. The 2010 indicator is used as a proxy.

The 2010 indicator reflects analysis of the state data from the pooled 2009 and 2010 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Notes - 2010
The 2010 indicator reflects analysis of the state data from the pooled 2009 and 2010 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Notes - 2009
The 2009 indicator reflects analysis of the state data from the pooled 2008 and 2009 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

a. Last Year's Accomplishments
Since 1996 there has been a considerable decrease in the percentage of Maine children without health insurance. In 1996, 15% of Maine children were without health insurance. According to 2009-2010 Current Population Survey estimates, 5% of children under age 18 in Maine were without any health insurance. About 39% were covered by MaineCare and 51% were covered by private health insurance. The US child uninsured rate was 10% in 2009-2010; Maine is tied for fourth for low rates of uninsured children in the U.S. Maine ranks 40th out of 50 states for the highest percent of children insured by Medicaid. By ensuring access to school-based health centers (SBHC), home visiting, and public health nursing (PHN), Maine's Title V program is

working to decrease or maintain the percent of children without health insurance in the State.

SBHCs provide a safety net for children who might not otherwise seek needed health care services. While not every community has created the necessary partnership between health care providers and schools, there continue to be 27 schools with SBHCs in the state. The Teen and Young Adult Health (TYAH) Program provided base funding for 18 SBHCs. 5,440 students were enrolled in these 18 funded SBHC's in Maine during FY11. There were 12,408 encounters, 38% of all visits were for mental health services and 46% of the primary diagnoses at medical visits were for preventive care services. About 68% of users were screened for major adolescent risk behaviors; including tobacco use, physical inactivity, poor nutrition, sexual activity, substance abuse, depression and behaviors connected to unintentional injury. Of those students using the SBHC, 86% were identified as needing mental health care and receive it at the SBHC. The remaining 14% may have received care outside of the SBHC.

90% of SBHC enrollees had an identified primary care provider (PCP), 89% of those enrolled in SBHC's had insurance (public or private), 42% with MaineCare, 30% private, while 4% had no insurance or were self-pay and 7% were unknown (they did not indicate coverage). SHBC staff assisted those children without insurance in getting connected with insurance providers. Data on SBHC services continued to improve in quality and detail through the assistance of an in-state helpdesk, and contracted data analysis services.

During FY11, of the 3,729 clients served by Community Health Nursing (CHN), 39% were insured through MaineCare, 46.1% had private insurance, and <1% had no insurance. The focus of CHN is to ensure clients obtain access to a PCP to obtain the required health care. They do monitor whether or not the client has insurance and provide clients with information on how to obtain insurance.

99% of children enrolled in the Maine Families Home Visiting Program (MFHV) in FY11 had access to a PCP and 97.3% had health insurance, 72.2% through MaineCare (this percent varies by area of the state). Key to this high rate of insured children is the referral for eligibility determination made during the initial family engagement. The remaining 2.7% of uninsured children represent those in the process of applying for MaineCare, those who are in the period of time before private insurance becomes valid, those whose children may be in state custody, or those whose circumstances are complex because of job loss and subsequent loss of insurance. Families with children who could potentially be eligible for MaineCare were encouraged and assisted to apply if they were willing. Federal eligibility changes such as family stress, substance abuse/domestic violence, low student achievement, tobacco users in the home has resulted in the MFHV program seeing a more vulnerable at risk population than in previous years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. School-based Health Centers providing assessment of insurance status, education and assistance in enrollment.		X		
2. Monitor changes in insurance coverage.				X
3. Monitor for changes in MaineCare services and work with the Office of MaineCare Services to facilitate MaineCare reimbursement for adolescent health services.				X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
A Request for Proposals was released in January 2011 and the TYAH Program awarded 8 SBHC grants for 16 sites. The TYAH Program is continuing the evaluation contract to support better data collection, seek opportunities to improve services and sustainability of SBHCs, including promoting preventive health, addressing behavioral health issues, and expanding partnerships.

Most SBHC's have transitioned to electronic medical records (EMR) creating some challenges in transmitting data to the evaluator in a usable format. Technical problems are being resolved. The database software, Clinical Fusion (CF), used by Maine's SBHCs that do not have an EMR was developed years ago in Colorado, has not had any significant upgrades for a number of years and none are anticipated in the future. Evaluators continue to work with SBHCs on extracting and reporting the required data from their EMRs as they transition away from CF.

c. Plan for the Coming Year
Given the passage of the Affordable Care Act, we expect the number of uninsured children in Maine to decline as persons are required to purchase health insurance.

MFHV programs not only document the insurance status of enrolled children but also track reasons why children are not insured. In some instances parents choose not to enroll in public health insurance when they initially begin to participate in the MFHV Program. Because home visitors are trained to engage families in the steps to promote child health and well being, each family's barriers are addressed individually, and home visitors may assist families in the application process.

Given the ongoing state budget deficit Maine is unable to increase the percentage of insured children using state funds. Most of the components of the Patient Protection and Affordable Care Act (PPACA) will not be implemented until 2014. The percentage increase of those children insured through MaineCare is limited as the income eligibility level is at 200% of the federal poverty level (FPL). The focus of the current administration's proposed cuts is on childless adults insured through MaineCare. The majority of the services for children remain intact though a proposal has been proposed to reduce eligibility from 200% of FPL to 133% of FPL.

SBHCs were level funded for FY13 however we are uncertain about funding in subsequent years.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	31	30	36	30	31
Annual Indicator	38.0	37.9	30.9	32.1	32.1
Numerator	4685	5016	5845	4600	4600
Denominator	12337	13239	18911	14330	14330
Data Source		Maine WIC Program	Maine WIC Program	Maine WIC Program	Maine WIC Program
Check this box if you cannot					

report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	31	30.5	30	29.5	29

Notes - 2011
Data are from the Maine WIC Program, CY10. The WIC program is undergoing a database revision due to problems with the current system and data for 2011 were not available at the time of submission. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

Notes - 2010
Data are from the Maine WIC Program, CY10. The WIC program is undergoing a database revision due to problems with the current system. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

Notes - 2009
Data are from the Maine WIC Program. The WIC program is undergoing a database revision due to problems with the current system. The new database will be active in summer 2012. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

a. Last Year's Accomplishments
Maine uses data collected by the local WIC agencies to determine the percent of children > 2 years enrolled in the WIC Program at or above the 85th percentile for weight. Due to changes in the WIC data system that have been implemented over the past year new data are not currently available for this measure. Based on WIC data from 2010, 18.4% of children between the ages of 2-5 who were enrolled in WIC in CY2010 were overweight (BMI between 85%-95%) and 13.7% were obese (BMI >95%). Overall, 32.1% had a BMI over the 85th percentile for their age.

The Maine CDC WIC Nutrition Program continued to work with local agencies on the Value Enhanced Nutrition Assessment (VENA) initiative developed jointly by the Food and Nutrition Service and the National WIC Association to improve nutrition services in the WIC Program. The State WIC Agency also conducted a special project grant funded by the Food and Nutrition Service, Revitalizing Nutrition Education through VENA: Skill Building for Cultural and Linguistic Competence. This project tested an approach and model for continuous skill building in cultural and linguistic competence to improve staff and organizational performance in providing WIC services. Results of this three year grant will be reported in 2012.

During FY11 the WIC Program developed a WIC participant handbook by consolidating information from several sources. It was designed to be used as a quick resource while shopping for groceries. The handbook includes a section on healthy foods.

With the release of the new participant handbook, the WIC Program revised its policy, with vendor approval, to allow participants to pay any overage above the face value of the fruit and vegetable voucher, in part, to reduce any potential anxiety for participants when checking out purchases. The change to allow participants to pay the overage will begin on October 1, 2011.

The WIC Program converted its growth charts from paper to electronic charts. We anticipate this move to significantly reduce staff error and increase accuracy of nutrition risk assessment.

A session at the Maine WIC Annual conference in October 2010 was devoted to a discussion of childhood overweight and obesity messaging. Strategies were shared by a Maine pediatrician, including an emphasis on helping parents recognize when there is a weight problem with their child and the idea of 'low hanging fruit' messages that steer parents to making small but significant changes in family eating habits: screen time, eating at home, portion sizes, soda intake and walking. Staff was able to take away usable counseling ideas for working with parents who have an overweight child.

During FY 2011, The Maine Nutrition Network worked with five local WIC agencies to provide education on vegetables, as a supplement to WIC nutrition education. The objective was to increase vegetable intake among WIC families. Barriers to vegetable intake for WIC families include lack of cooking skills, inability to afford vegetables, unfamiliarity with a variety of vegetables, and dislike of vegetables by one or more family members. Each agency offered cooking demonstrations on six different vegetables throughout the year. Clients were invited to participate either before or after their regularly scheduled WIC visits. Cooking skills, taste-testing and food resource management skills were highlighted. Children were also invited to taste-test and to "help" with basic preparation of the vegetable. The Program Manual included directions for carrying out a cooking demonstration for each of the six vegetables. Recipes and educational handouts were provided to the agencies to distribute to WIC clients at the cooking demonstrations. These included: fact sheet and recipe for the vegetable being taught, planning to save money when buying food, finding the best buys for your food dollar when shopping, cooking made easy, making family meals enjoyable, being a healthy role model for your child, and taking advantage of seasonal deals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate WIC agency contract indicators to achieve the WIC goals.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY12 the WIC Program will issue a Request for Proposals (RFP) for the provision of online nutrition and health education services to low-risk participants enrolled in the WIC program. Anticipated objectives include; reduction of missed appointments as participants can take the education module at any time, decreased scheduling conflicts for nutrition education appointments, increased appointment time available for enrollment and high-risk one-on-one appointments. We anticipate funding eight agencies across the state.

The WIC program conducted an extensive review and update of all policies and procedures for the FY2012 State Plan.

The October 2011 annual WIC Conference featured keynote speaker Dayle Hayes who presented on the topic "New Guidance, Positive Messages: What the Dietary Guidelines and My

Plate Mean for You and WIC Families". Establishing short-term, achievable goals with participants was included in the keynote sessions.

The WIC Program strategic planning process was placed on hold due to budget cuts.

c. Plan for the Coming Year

The WIC Program will focus on attaining two goals: 1) Maine WIC participants will have improved health and well-being through access to quality WIC nutrition services; and 2) the Maine WIC Nutrition Program will provide effective, efficient and culturally sensitive services to all WIC participants. The nutrition education indicators outlined in the WIC agency contracts that reflect these goals are: 1) increase the number of WIC participants who are at a healthy weight and 2) ensure that all WIC staff reinforce VENA methods in participant nutrition assessments.

The Maine WIC Nutrition Program will focus on reducing the number of WIC children who are overweight. The Program will collaborate with local WIC agencies as well as other partners to enhance strategies that will help to reduce the rate of overweight children in Maine.

The State WIC agency will continue to monitor food benefit changes to determine their impact. Redemption of the monthly cash value vouchers will be assessed, with participant and vendor feedback used, to focus activities for improving use of this benefit.

The State WIC Agency rolled out its new program application, with one agency in pilot, during April 2012. Other agencies will be trained and brought onto the application one at a time, with an anticipated completion by September 30, 2012. The new application will provide improved reporting on participant health outcomes.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	17	16.5	19	18	21
Annual Indicator	19.9	19.4	21.2	18.2	18.2
Numerator					
Denominator					
Data Source		Maine PRAMS	Maine PRAMS	Maine PRAMS	Maine PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18	17.8	17.6	17.4	17.2

Notes - 2011

Data for this measure are from the Pregnancy Risk Assessment Monitoring System (PRAMS). 2011 PRAMS data are not yet available. Therefore, 2010 data are used as an estimate.

Notes - 2010
Data for this measure are from the 2010 Pregnancy Risk Assessment Monitoring System (PRAMS).

Notes - 2009
Data for this measure are from the 2009 Pregnancy Risk Assessment Monitoring System (PRAMS).

a. Last Year's Accomplishments
The 2010 Maine Pregnancy Risk Assessment Monitoring System (PRAMS) indicated that 18.2% of pregnant women smoked during the last three months of pregnancy. There has not been a statistically significant change in the smoking rate among pregnant women over the past five years. Despite no significant changes in the prevalence percentage, Maine's Title V program and the Partnership For A Tobacco-Free Maine (PTM) remain committed to reducing the percentage of pregnant women who smoke.

Although approximately 20% of pregnant women smoked during their pregnancy; 31% of MaineCare insured women smoke during pregnancy compared to 4% of non-MaineCare insured. Of all pregnant women who smoke, most are MaineCare insured, are young, live in poverty, are less educated, are more addicted to tobacco and are the most challenging population to help quit. By collaborating with those who serve populations disproportionately affected by tobacco use (Maine WIC Program, Perinatal Outreach Nurse Educator, American Heart Association, Women and Heart Health Committee, Maine Women's Health Campaign, and Maine Breast and Cervical Health Program [MBCHP]) PTM has been able to reach pregnant women who smoke. The Center for Tobacco Independence (CTI), trained 90% (104) of the MBCHP primary care sites to screen women, receiving a mammogram or pap smear, for tobacco use and to refer them to the Maine Tobacco HelpLine (MTHL) for tobacco treatment. Some Federally Qualified Health Centers (FQHC) and family planning providers who serve pregnant women in rural areas of Maine were also trained.

L.D. 216 (became law in April 2011) Resolve, Regarding MaineCare Tobacco Treatment and Smoking Cessation Benefits directed the DHHS, through the PTM and Office of MaineCare Services (OMS), to work to address the high tobacco use rate (41.4%) among MaineCare members (MaineCare Insurance Status, 2010), which is double the statewide average of all Maine residents (BRFSS, 2010). MaineCare claims data revealed that cessation benefits were being underutilized by MaineCare insured. Discussions with the MaineCare Physician and Dental Advisory Committee and various provider associations identified the needs of providers in helping members to quit. In April 2011 a packet was mailed, to all physician practices who serve MaineCare insured, that included an excerpt from the Surgeon General's Report on "How Tobacco Smoke Causes Disease", a poster with pull-off information about the MTHL, a one-page guide of costs covered through MaineCare for tobacco cessation, and an article on using the tobacco treatment intervention from the Public Health Services Guidelines for using the 5A's of tobacco intervention: Ask, Advise, Assess, Assist and Arrange to assist in encouraging patients to quit. An important component was an emphasis on the use of the fax referral line when a physician is able to obtain agreement to refer, the patient will receive a pro-active call from the MTHL. MTHL statistics show that 57% of patients referred by fax enroll in the quit program. The number of callers to the HelpLine was tracked through a series of three questions; 44 callers to the HelpLine during FY11 were currently pregnant, 34 were planning a pregnancy within 3 months, and 22 were currently breastfeeding. PTM HelpLine brochures continue to be placed in all MaineCare offices.

PTM continued to promote easy to read materials that can be ordered from the PTM store (www.ptmstore.org); 4,267 "What Women Need to Know About Tobacco" brochures, 100

Nicotine Replacement Therapy Cards, 12,192 Quit Brochures, 16,898 How the HelpLine Works, 1,566 QuitLink Handout Cards and 5,533 Spit Tobacco Brochure Cards were ordered during FY11.

The presentation, Confident Conversations, was developed specifically for social service providers, to teach them how to refer clients to the MTHL for help quitting tobacco use.

The Maine Families Home Visiting Program (MFHV) continued to have staff participate in the "Basic Skills Training" to develop and enhance their skills on giving brief tobacco interventions to their clients. Overall 34% of mothers smoked upon enrollment. Of those, 25% subsequently quit, 30% reduced their smoking, 23% were contemplating reduction or were trying to reduce, and 23% had no change in smoking behavior. The main focus of the home visitors work with families around tobacco is on the child's exposure. Of the 598 children exposed to second-hand smoke, exposure was eliminated for 39% and reduced for 29%.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Basic Skills Trainings for healthcare, social service, and other providers.				X
2. Promote the Maine Tobacco HelpLine through print and other media.		X	X	X
3. Collaborate with MCH programs and Office of MaineCare Services to increase use of benefits coverage for tobacco cessation treatment for pregnant women referrals.		X		
4. Promote programs and messages at the local level through the Healthy Maine Partnerships.		X		
5. Collaborate and expand partnerships with other Maine CDC programs (WIC, Women's Health Initiative) and Office of Substance Abuse to address quitting with their clients.		X		X
6. Increase capacity of local organizations and grantees to address priority populations using results from the Partnership for a Tobacco-Free Maine Five Year Strategic Plan.				X
7. Evaluate programs and track prevalence rates.				X
8. Provide proactive counseling to all pregnant women through the Maine Tobacco HelpLine and face to face coaching.			X	
9.				
10.				

b. Current Activities

A model tobacco policy developed in FY11 asked MBCHP providers to routinely screen patients for tobacco use and secondhand smoke exposure. Tobacco users are advised to quit and are referred to the MTHL. Implementation is voluntary but ensures all tobacco users are offered tobacco treatment. CTI sent follow-up letters offering a one hour in-service training on the use of the 5A's and the MTHL.

On January 1, 2012 Maine became the first state in the nation to protect tenants from secondhand smoke when the 20 public housing authorities across the state adopted a smoke-free policy. In addition, all property owners and managers are required to notify all tenants, in writing, about the current smoking policy on the property when the landlord and tenant enter into a rental agreement. We hope this policy will reduce exposure to second and thirdhand smoke and encourage pregnant women who smoke to think about quitting.

The release of the 2010 Surgeon General's Report How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease inspired PTM to create hard hitting messages explaining exactly how tobacco and its chemicals cause disease in the mom, fetus, and baby. A series of three cards are being developed to explain the effects on the mother, fetus, baby and child (one card at each doctor visit). The cards explain how to approach and advise about tobacco treatment. A chart is included for providers to follow the quitting progress at each visit.

c. Plan for the Coming Year

We anticipate proposed FY13 funding cuts coupled with the retirement of a critical staff connection at the OMS will impact any significant progress on this measure. During FY13 PTM will continue to collaborate with MaineCare, MaineCare providers, WIC and MBCHP to refer their clients to the MTHL. PTM will work to establish new relationships at OMS when this position is filled. Focus groups will be conducted with MaineCare tobacco users to determine how to increase the use of cessation benefits.

PTM, CTI, and the media contractor will complete development of the pregnant woman tool kit for healthcare providers and begin training providers at all Clinical Outreach Trainings.

PTM will analyze PRAMS data to identify potential issues, such as domestic violence, that influence pregnant women who smoke.

PTM will assist local coalitions to deliver the Confident Conversations presentation to appropriate social service providers. A database of Confident Conversation evaluations will be maintained, including the type of organization selected and number of staff trained.

Collaborate with MFHV Program to train new staff on the Basic Skills Training for tobacco treatment.

Collaborate with the Fetal Alcohol Spectrum Disorder (FASD) initiative to inform parents about the dangers of alcohol, tobacco, second and thirdhand smoke. FASD is a four year Federal Maternal, Infant, Early Childhood, Home Visiting (MIECHV) Expansion Grant to develop prevention, intervention, and treatment services for young children and their families in Maine. PTM will also provide resources for the MTHL.

The MFHV program has been and continues to be challenged with curtailment orders and proposed funding cuts. Proposed FY12 funding reductions, although reinstated, resulted in reductions in services due to loss of staff. During FY13, as funding permits, the MFHV Program plans to formalize its screening program for pregnant women and parents with newborns. MFHV will be using a behavioral health risk screening tool that looks at substance use and domestic violence and has a specific question about tobacco. The screening will be conducted prenatally and postpartum with all women.

Relative to L.D. 216, "Resolve, Regarding MaineCare Tobacco Treatment and Smoking Cessation Benefits", and dependent upon MaineCare staffing, PTM will partner with MaineCare and CTI to provide training at provider association meetings and statewide events where providers gather, to assist with motivational interviewing and the 5A's; and provide training opportunities for providers at the Annual Conference on Tobacco and Cessation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9.2	8.3	9	9.8	7.7
Annual Indicator	10.0	9.9	7.8	8.8	8.8
Numerator	46	45	35	39	39
Denominator	460684	454793	449300	443305	443305
Data Source		Death certificates, Maine Vital Statistics Office	Death certificates	Death certificates	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8.6	8.5	8.4	8.3	8.2

Notes - 2011
2011 mortality data are not yet available. The 2010 indicator is used as an estimate.

The 2010 indicator is the 5-year average for 2006-2010. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics

Notes - 2010
The 2010 indicator is the 5-year average for 2006-2010. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Denominators are based on US census estimates as of July 1.

Numerator data are from the Maine Office of Data, Research and Vital Statistics

Notes - 2009
The 2009 indicator is the 5-year average for 2005-2009. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics

a. Last Year's Accomplishments
Suicide and suicide attempts have immediate and long-term financial, emotional, and social consequences. Many more people survive suicide attempts than die by suicide. This is especially true among youth who attempt at much higher rates than their adult counterparts. Suicide is a leading cause of death in Maine. Based on data from 2005-2009, the most recent national data available, Maine's suicide rate among 15-19 year olds of 7.8 per 100,000 ranked 33rd highest in the U.S. The 2006-2010 rate increased slightly to 8.8 per 100,000. There has been an increase in the overall number of suicides in Maine in recent years, from an average of 168 per year between 2004 and 2006, to 188 deaths per year between 2007 and 2009. Although it is too soon to know whether the suicide rate increase will continue to trend upward in Maine, it is cause for concern and provides a strong impetus to focus on suicide prevention initiatives.

Youth between the ages of 15-24 had the highest rates of hospitalization for a self-inflicted injury (15.1 per 10,000) among all age groups in 2009. Females represented 60.2% of these hospitalizations. Rates of inpatient hospitalization for self-inflicted injury among this age group have not changed significantly over the past five years. According to data from the Maine Youth Risk Behavior Survey (YRBS), between 1997-2011 the % of high school students who reported considering, planning or attempting suicide within the past year declined substantially. In 1997, almost 1 in 4 (24.5%) of high school students considered suicide within the past year; in 2011, based on the Maine Integrated Youth Health Survey, this decreased to about 1 in 8 (12.7%). The rate of Middle school students reporting ever considering, planning or attempting suicide has also declined substantially. In 1997, 30.4 % of students reported ever considering suicide and in 2011 14.5% reported ever seriously considering suicide.

Since inception, the Maine Suicide Prevention Program (MSPP) has had a strong focus on reaching school-aged youth using school-based evidence-based programming and we believe this has influenced our rates of suicidal behaviors and deaths in Maine. Saving young lives at risk involves a diverse range of interventions including effective identification and treatment of those with mental health disorders, promotion of help-seeking, early detection of and support for youth in crisis, reducing access to lethal means, life skills training and building protective factors such as connectedness. A youth suicide impacts family, friends, peers, school systems and community members in significant ways and for many years. It is far better to prevent suicides by getting young people supported and connected to the help they need and these youth are more likely to lead productive lives in the future. Quoting from a parent; "I will live the rest of my life wishing I had known what I know today. My hope is that by telling my story, no one will ever have to say I wish I had known. I can no longer save my son, but I hope to save other families from having to live with the pain that my family will live with for the rest of our lives."

The program's partnership with the Maine Primary Care Association (MPCA) continued its implementation of action steps identified at the 2010 symposium. This includes a pilot of the National Suicide Prevention Resource Center, Western Interstate Commission for Higher Education, toolkit to integrate suicide prevention and intervention into community health center practices.

Training is a cornerstone of the program; 52 programs were conducted and reached 1440 individuals, many of whom work with youth and families. Specific programs delivered included: 18 gatekeeper for 363 participants; 5 clinician assessment for 78 participants and 19 awareness education presentations reaching 558 participants. The annual Beyond the Basics conference was attended by a statewide audience of 288 from various settings including middle and high schools, colleges, military, law enforcement, mental health and primary care.

The Department of Education (DOE) includes a section specific to injury and violence prevention and mental health in its Linking Key Concepts to the Maine Health Education Standards, a document that links key education and prevention concepts to the health education standards

and performance indicators in the Maine Learning Results.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate statewide access to crisis assistance and suicide prevention resources through promotion of statewide hotline and website.			X	
2. Provide suicide prevention training and education programs statewide.				X
3. Provide suicide prevention and intervention guidance and technical assistance to school, community and health care personnel.				X
4. Conduct surveillance of, analyze, interpret and disseminate reports on self-inflicted injuries and suicide among youth.				X
5. Support implementation of program plan goals, objectives and activities as resources permit.				X
6. Maintain and form new partnerships to effectively integrate youth suicide prevention activities in related programs and services.				X
7. Work collaboratively to improve the quality and timeliness of self-injury data.				X
8.				
9.				
10.				

b. Current Activities

A new training contractor was selected in FY12; the National Alliance on Mental Illness of Maine (NAMI Maine) in partnership with the Co-Occurring Collaborative Serving Maine (CCSME) and the MPCA conducted training programs that include: 13 gatekeeper for 269 participants; 5 clinician assessment for 113 participants; annual conference for 140 and 25 awareness education presentations reaching 688 participants. In all, the training program conducted 53 programs and reached 1300.

The youth suicide prevention plan was combined with the updated adult suicide prevention plan. Feedback from Maine stakeholders was received and incorporated into the new suicide prevention plan. A draft is located at: http://www.maine.gov/suicide/

Following the suicide of a nine year old, the Maine Child Death and Serious Injury Review Panel and the Maine Children's Advocacy Network initiated an examination of youth suicides. Training of participants has occurred, cases have been selected for examination and review dates have been established.

Using the National Violent Death Reporting System model, we collected data on 124 youth suicides from 2005-2010 and produced a report (included in appendix). Data analysis included examining circumstances, risk factors and risk behaviors of suicide decedents. The Medical Examiner's Office provided access to medical examiner reports, death certificates, police reports and medical records.

c. Plan for the Coming Year

Performance objectives for the coming year are directly tied to available funding, and program planning that is currently underway. Reducing youth suicide and suicide attempts in children aged 10-24 requires a multi-pronged effort and presents multiple challenges. The MSPP currently has no federal youth suicide prevention funding to support school and community prevention. Thus, the reach of the program to Maine schools and communities will be limited; state cuts to mental health services may also impact Maine's suicide rates. Evaluation services to monitor the impact of program services are significantly reduced with the lack of federal funding. Statewide training services and technical assistance to schools and communities will remain available utilizing state MCH match funds, but resources will be significantly limited as compared to previous years when federal grant funding was in place.

Through the training contract with NAMI Maine, the MPCA and the CCSME, suicide prevention training programs will be delivered statewide. Training will reach professionals in school, community, professional, clinical, primary care settings and public safety venues. Training programs include: Gatekeeper training, training of trainers, awareness education, Lifelines, Transitions and Middle School Lessons teacher training, clinician and primary care provider training, an annual suicide prevention week event, and annual suicide prevention conference. Training evaluation findings will inform improvements to all training programs and venues.

Planning is underway to address youth at risk for suicide; this includes tribal members, youth in the military and sexual minority youth. The program plans to explore use of the "Family Acceptance Project" to reduce suicidal behavior among LGBTQ youth and young adults.

We will continue to promote the 24-hour crisis hotline, collaborate with stakeholders and partners statewide to advance effective suicide prevention, monitor trends in suicide and self inflicted injuries among Maine youth, and distribute updated fact sheets and resource materials in a variety of formats. We will update the program website to include recent data, the program plan and links to resources and will continue to explore methods to effectively use technology to reach the youth audience.

The program will continue to work on integration of suicide prevention screening, assessment and training into behavioral health and primary health care settings. We expect to partner with the Maine Primary Care Association and other primary care associations to integrate suicide prevention screening, assessment, and treatment within behavioral health care in Maine's Federally Qualified Health Centers.

The DOE and MSPP will continue to work together to train teachers on Lifelines Student Lessons and Transition Student Lessons in high schools and to modify the Middle School Student Lessons and accompanying teacher training.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	81.5	82.2	82.3	84	83
Annual Indicator	82.1	81.8	83.5	82.8	83.2
Numerator	690	667	662	617	593
Denominator	840	815	793	745	713
Data Source		Birth certificates,	Birth certificates	Birth certificates	Birth certificates

		Maine Vital Records Office			
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	83.5	84	84.5	85	85.5

Notes - 2011
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2011 indicator is the 5-year average for 2007-2011. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from birth certificates and were provided by the Maine Office of Data, Research and Vital Statistics.

Notes - 2010
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2010 indicator is the 5-year average for 2006-2010. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from birth certificates and were provided by the Maine Office of Data, Research and Vital Statistics.

Notes - 2009
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2009 indicator is the 5-year average for 2005-2009. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from birth certificates and were provided by the Maine Office of Data, Research and Vital Statistics.

a. Last Year's Accomplishments
In 2010, 82.6% of Maine's very low birth weight (VLBW) infants were born at specialized facilities. The small number of VLBW babies born in Maine each year (~120 per year) can lead to substantial variability from year to year on this measure. Examining five-year moving average since 2000, Maine's performance on this measure has ranged from 80.6% in 2000-2004 to 83.2% in 2007-2011.

Maine has two Level III nurseries, Eastern Maine Medical Center in Bangor and Maine Medical Center (MMC) in Portland, and one Level II nursery, Central Maine Medical Center in Lewiston. Given the geography of the state and the population distribution it is not reasonable to expect that all VLBW infants will be delivered at Level III hospitals. The neonatal transport system and statewide perinatal education and consultation are important factors in obtaining better outcomes for pre-term infants born in Maine.

The Maine Maternal Fetal and Infant Mortality Review (MFIMR) Panel met three times in FY11. The Panel continued to address specific risk factors for infant mortality that have emerged as growing concerns in Maine. The following issues were identified as needing in-depth investigation: factors that contribute to pregnancy loss, specifically fetal deaths greater than 28 weeks and strategies for prevention; barriers to delivery of the highest risk infants at hospitals with appropriate facilities and professionals to provide the best chance of survival for the infant (i.e. Level III facilities); and Sudden Infant Death (SID) and Sudden Unexpected Infant Death (SUID), including sleep related deaths.

Panel recommendations included facilitating educational efforts to increase awareness of factors contributing to maternal, fetal and infant deaths in Maine: preterm birth risk; access to high risk birth facility and to promote appropriate health, behavior and safety screening for all pregnant women; promote infant safe sleep practices; and identify depression and other needs of bereaved families. Other recommendations included: promoting follow-up care for women and infants; and promoting bereavement and other services available for families who have experienced a death of a mother, fetus or infant.

Reporting on L.D. 2253, "An Act to Provide Access to Certain Medications to Certified Midwives" began in late FY09. The MCH Team monitors the use and complications related to the use of these medications, primarily pitocin. During FY11, eight reports were received from midwives related to patients requiring the use of pitocin for postpartum hemorrhage. Of those receiving the medication, one patient required two doses and was transported to the hospital and three patients had retained placentas and were transported to the hospital.

The MCH Team continued to collaborate with the Perinatal Outreach Education and Consultation Program (POEC) at MMC. The POEC provided education and consultation and assumed a leadership role in a variety of public health activities, including the MFIMR process. The POEC contributed to the quality of perinatal care in Maine by providing 50 formal lectures for 1,099 attendees during FY11. Topics included; Perinatal Addiction and Neonatal Narcotic Abstinence, Neonatal Resuscitation, Late Preterm Birth: Perinatal and Neonatal Concerns, using the Edinburgh Postpartum Depression Tool, interdisciplinary lectures on Shaken Baby Prevention in Maine and the Period of Purple Crying (POPC). In addition, 11 perinatal transport conferences were provided for 167 attendees.

The Maine Children with Special Health Needs/Genetics Program assisted the POEC Program, through grant funds, to purchase a SimNewB, an electronic training tool for resuscitation and stabilization of neonates. In November the perinatal outreach team traveled to a Simulation Instructor course at The Center for Advanced Pediatric and Perinatal Education at Stanford. The neonatal mock code team began facilitated neonatal resuscitation simulations at four facilities with a total of 67 participants. The simulator has helped hospitals evaluate their skills in a more concrete manner.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide education to perinatal care providers regarding high risk care and monitor trends in service delivery.				X

2. Assure statewide access to perinatal and neonatal transport systems.	X	X		
3. Partner in the Prematurity Prevention Campaign led by the March of Dimes.			X	X
4. Monitor health and safety of home births.				X
5. Continue to develop quality improvement prematurity model.				X
6. Develop prematurity model for ChildLINK.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Maine Children with Special Health Needs Program (CSHN) is currently working on a quality improvement (QI) process to improve the referral and tracking process for pre-mature births in Maine. This QI project is focusing on the processes for ensuring that pre-term infants are referred to the Department of Education's (DOE) Child Development Services (CDS) (Part C) Agency; a result of a Memorandum of Agreement between DHHS and DOE mandating that DHHS collaborate with hospital NICU's to refer infants born prematurely to CDS as they are at increased risk for subsequent cognitive disabilities.

The CSHN Program is taking the lead in developing a module within ChildLINK to identify and track infants identified as premature. QI steps include identifying the current and future state, identifying roles and responsibilities of both the hospital and state systems, validating data and identifying key problem areas.

In early FY12, several provider concerns were expressed regarding a report on OB Emergency Sentinel Events Alert. Concerns included: lack of perinatal expertise in the sentinel events system; lack of awareness of practices, resources and systems of related specialty care, i.e. perinatal and neonatal care; and lack of specialist input to the report. Action steps were recommended to address the concerns with providers, partners and stakeholders.

c. Plan for the Coming Year

Continue to work with certified midwives to provide education and collaborate with them on newborn screening and medication requirements. The Department of Health and Human Services Childhood Death and Serious Injury Review Panel has been tasked with review of medical records of mothers or infants who were expecting a home birth and were transferred to a hospital. The focus of this review is to identify risk factors and management issues that contribute to positive and negative outcomes for planned home births.

Continue educational efforts to increase awareness related to factors contributing to maternal, fetal and infant deaths in Maine.

Continue to review cases of infant deaths through the MFIMR panel. The Coordinator will consider adding new members to the Panel to assure all stakeholder groups are represented.

Continue to consult with MCH Medical Director and other consultants on perinatal issues.

Based on the trend of the past ten years, we hope to make incremental improvements in this measure over the next three years. We anticipate that these changes will be possible through the work of the MFIMR panel and ongoing epidemiologic analyses of this issue. In addition, the new regional public health infrastructure will allow us to focus our efforts to specific parts of the state

where this is an issue.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	90	90	90	90	89.5
Annual Indicator	87.1	86.8	87.6	89.4	89.0
Numerator	12295	11813	11801	11579	11308
Denominator	14110	13605	13466	12950	12700
Data Source		Birth certificates, Maine Vital Records Office	Birth certificates	Birth certificates	Birth certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	89.6	89.7	89.8	89.9	90

Notes - 2011
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics. Data are from 2011.

Notes - 2010
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics. Data are from 2010.

Notes - 2009
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics. Data are from 2009.

a. Last Year's Accomplishments
Efforts to increase early receipt of prenatal care are based in Maine Families Home Visiting Program (MFHV), Public Health Nursing Program (PHN), Community Health Nursing (CHN) and WIC Nutrition Program. Between 1999 and 2011, there has not been a statistically significant change in the percent of women receiving prenatal care beginning in the first trimester. Each year about 88% of women in Maine receive prenatal care in the first trimester; 89.0% received prenatal care in the first trimester in 2010. In 2007, the most recent year with comparable US data, 82% of

US women received prenatal care in the first trimester (based on states using the unrevised birth certificate). Maine is in the process of switching to the 2003 revised birth certificate.

The MFHV Program is open to any teen parent and first time family throughout the state. Efforts are made to enroll women prior to giving birth to ensure optimal prenatal care and to have the greatest impact on developmental outcomes for the baby-to-be. During FY11 twelve agencies in all 16 counties provided 18,907 home visits to 2,375 families. Nearly 40% of new participants in FY11 enrolled prenatally in the MFHV program. Parents reported that their participation in home visiting has contributed to positive changes in many areas as a result of information provided by the program: home safety (98%), child nutrition (98%), car safety (96%), breastfeeding (91%) and exposure to second hand smoke (92%). In FY11, using the Kotelchuck Index to measure adequacy of prenatal care, 93% of participants with babies born during that year attained adequate care. Of the 934 newly enrolled mothers in the MFHV, most enrolled during the last trimester.

Changes over the last two years related to funding instability impacted MFHVs capacity to enroll all eligible families prenatally. The threat of State funding elimination over most of the second half of the fiscal year resulted in lost staff and diminished capacity. The decrease in staffing resulted in less outreach by some MFHV sites as they had maximized their enrollments and had waiting lists.

Prenatal referrals to PHN have been relatively low, representing 2.4% of all PHN and 2.5% of all CHN visits. PHN outreach consisted of providing hospitals and providers with information on services. Scheduled visits by PHN supervisors and PHN hospital liaison nurses were utilized to increase partner awareness of available services. The primary referral source for PHN home visiting is through childbirth classes which are generally in the last trimester, thereby decreasing the likelihood of a prenatal PHN visit. OB/GYN's generally only refer if the mother is considered at risk. There has been no significant increase in prenatal referrals.

The WIC Nutrition Program collaborated with PHN staff and other partners to enhance provision of services to pregnant women in their first trimester. The WIC program experienced an approximate 25% funding cut in FY11. WIC enrollments remain high at 26,000; the average pregnant women enrollment has remained constant at approximately 2300- 2400. High caseloads has challenged WIC agencies as Food Nutrition Services decreased funding of WIC administration translates to fewer staff managing increased caseloads. A one-time saving measure that has been implemented by agencies is group enrollment of pregnant women. General program information was delivered in this format rather than the traditional one on one and has proved to be a very effective measure in getting pregnant women enrolled within the federal timeline requirement. When a client is enrolled in WIC and is pregnant they are asked if they are receiving prenatal care and the enrollment health history has an option for a pregnant woman to check at the first visit if they are receiving home visiting services.

The WIC program conducted a cost analysis of its satellite outreach clinics and determined that the cost to maintain the clinics compared to the number of participants was not cost effective therefore deciding to close several clinics. In addition outreach efforts to target those women in their first trimester of pregnancy have been curtailed considerably with no plans to resume in the foreseeable future.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide services to families with identifying health needs and Maine Families Home Visiting providing non-medical family support and parent education services.	X			X

2. Provide technical assistance to providers of parent education and support services related to implementation and maintenance of parent and education and support services.				X
3. Enhance collaboration between the local WIC agencies, Public Health Nursing and other partners to enhance access to services for pregnant women.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC program is in the final stages of converting to a new data collection system, Successful Partners in Reaching Innovative Technology (SPIRIT). Piloting took place in April and implementation rollout began in May with full rollout anticipated to be completed in September. SPIRIT replaces the Legacy system that has been in place for close to 20 years.

The Breastfeeding Peer Counselor Program is active in six of our eight WIC agencies in Maine. The goal of the program is for a peer who has breastfed to support both pregnant and postpartum women in their efforts to breastfeed their babies. Educating pregnant women about the benefits of breastfeeding is especially important.

A new PHN nurse supervisor in Aroostook County, who has an MCH background, has been visiting physician offices and hospitals in an effort to reinvigorate prenatal referrals. The PHN Program will evaluate the results of her efforts and if successful (increased referrals) will consider carrying out similar activities in other areas of the state.

Community Health Nursing has been re-designing its data collection system in an effort to align more closely with the PHN CareFacts system as well as focus on data requirements for MCH measures. We anticipate the system will be operational by July 1, 2012.

c. Plan for the Coming Year

Maine's objective for this measure is that the percent of women receiving prenatal care in the first trimester reach 90%. This is the same as the HP2010 goal and the Healthy Maine 2010 for this objective. However, Maine is in the planning phases to implement the 2003 revised birth certificate. After implementation, our objectives will need to change due to non-comparability in measurement between the old and revised birth certificate forms for this measure.

The WIC Program will, as funding allows, focus on outreach efforts to increase the number of WIC women enrolled in the first trimester of pregnancy and add breastfeeding peer counselors.

The WIC Program will continue to collaborate with the local WIC agencies, PHN and other partners to enhance access to services for pregnant women.

The MFHV Program received a highly competitive Maternal, Infant and Early Childhood Home Visiting Program Expansion Grant in FY12. This grant is intended to expand capacity to reach the most vulnerable babies, especially drug affected and other high risk infants. The grant has a strong focus on prenatal enrollment, as well as increased collaboration among partners serving this population. About 30 new staff members will be hired and trained in the first year of the grant, creating greater capacity to add more families to the program.

The MFHV and WIC Programs will work together to explore ways to market services and create referral strategies that result in earlier referrals to each other's programs. WIC will also work with the Perinatal Nurse Managers to increase outreach.

D. State Performance Measures

State Performance Measure 1: *The rate of suicide deaths (per 100,000) among those age 20-44 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					16
Annual Indicator		15.5	16.2	16.4	16.4
Numerator		327	336	336	336
Denominator		2104059	2077465	2046551	2046551
Data Source		Death certificates	Death certificates	Death certificates	Death certificates
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	16.2	16.1	16	15.9	15.8

Notes - 2011
2011 death certificate data are not yet available. The estimate from 2006-2010 is used as a proxy.

Notes - 2010
2010 data are based on 2006-2010 death certificates from the Maine Data, Research and Vital Statistics Program. A 5-year estimate is used to make the estimate consistent with NPM#16: Suicide rate among 15-19 year olds.

Notes - 2009
2009 data are based on 2005-2009 death certificates from the Maine Office of Data, Research and Vital Statistics. A 5-year estimate is used to make the estimate consistent with NPM#16: Suicide rate among 15-19 year olds.

a. Last Year's Accomplishments
This measure was chosen because the Maine Suicide Prevention Program (MSPP) is expanding efforts to address suicide and self-inflicted injury among adults within the MCH population. The number and rate of suicides of the young and middle-aged is among the highest of any age group in Maine. Preliminary data from 2010 indicates, there were 65 deaths among Maine residents aged 20-44 years; 25% of these deaths were among women. Between 2006 and 2010, the suicide death rate among this age group was 16.4/ 100,000; there were 336 deaths during this 5-year period, approximately 67 deaths per year. Suicide rates among this age group have increased since 2003. Based on Maine Behavioral Risk Factor Surveillance System (BRFSS) data from 2006-08, the most recent available data, 3.8% of Maine adults between the ages of 20-44 years considered, planned or attempted suicide within the previous year (3.4% of women). Of those who reported recent suicide ideation or an attempt, 1 in 3 (33.7%) reported having a child

living with them. Among women who reported suicide ideation or an attempt, 40.6% had a child in the home.

Suicide is extremely traumatic for the family, friends, class-mates and community members who are left behind (survivors). In addition to the feelings of grief normally associated with a person's death, there may be guilt, anger, resentment, remorse, confusion and great distress over unresolved issues. Unlike deaths from other causes, suicide survivors experience a complicated and prolonged grief that can lead to depression. The stigma surrounding suicide can make it extremely difficult for survivors to deal with their grief and can cause them to feel terribly isolated. It is estimated that for each person who dies by suicide the number of people severely affected by the loss is between 5 and 10. This can represent a significant number as the circle is extended to include the contacts individuals and families make throughout their lives and within their communities. According to longitudinal research, children whose parents die by suicide are more likely to experience long-term psychological problems, including behavioral and anxiety symptoms, and increased risk for hospitalization for a suicide as adults, compared to children whose parents died by other causes.

The MSPP partnered with the Maine Primary Care Association (MPCA) to implement action steps from a 2010 symposium for suicide prevention integration into primary care. Resource information was gathered, compiled and distributed to all of Maine's Federally Qualified Health Centers (FQHCs). Information on available MSPP training programs was routinely distributed and FQHC staff were encouraged to attend at least some of the trainings. Three voluntary demonstration sites worked with the Western Washington Interstate /Suicide Prevention Resource Center, a nationally produced tool kit for primary care integration. These sites received on-site staff education and coaching calls. Two meetings were held with these sites to work on issues such as protocol development, referral relationship building, electronic medical records and communications.

Training sessions were held for faculty and staff in three colleges; training programs included: 18 gatekeeper for 363 participants; 5 clinician assessment for 78 participants and 19 awareness education presentations reaching 558 participants. The Beyond the Basics conference was attended by a statewide audience of 288 participants from various settings including colleges, military, law enforcement, mental health and primary care. In all, the training program conducted 52 programs and reached 1440 individuals.

The Adult suicide prevention plan was re-drafted to incorporate new developments in the national suicide prevention strategy. Feedback from Maine stakeholders was received and incorporated into the new plan.

Transition Guides were developed to accompany the Transitions Lessons and sent to all Maine high schools in May 2011 for distribution to high school seniors. A mother who lost her son to suicide in his first months of college was instrumental in this work and the Guides were sent under a cover letter from her. The story received prominent press coverage.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Facilitate statewide access to crisis assistance and suicide prevention resources through promotion of the statewide hotline and website.			X	
2. Support implementation of prevention plan goals, objectives and activities as resources permit.				X
3. Maintain and form new partnerships to effectively integrate suicide prevention activities in related programs and services.				X

4. Collaborate to improve the quality and timeliness of suicide and self-injury data.				X
5. Provide suicide prevention training and education programs statewide.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adult suicide prevention plan was completed and distributed to serve as a guide for suicide prevention activities aimed at Maine adults statewide.

Work to develop suicide prevention, intervention and postvention protocols for state employees was started. Approval to proceed was secured from the Maine CDC, the Departments of Health and Human Services, Education and Labor as well as the state Human Resources Department.

Work continued with the MPCA and demonstration sites to further suicide prevention integration into primary care settings. A December 2011 meeting featured a presenter on suicide prevention integration who described effective suicide prevention strategies for health centers. A total of 27 staff from 9 Health Centers attended MSPP trainings.

A training program and four meetings were held with the suicide survivors speakers group to provide current information and coordinate efforts. The group developed a brochure to promote their services and a kit for First Responders. Survivor speakers made 30 presentations reaching 1,000 people. The survivors worked with the statewide Information Resource Center to include materials for dissemination to families on mental illness, suicide and self-injury.

A brochure for female veterans returning from deployment was developed and distributed in cooperation with the Veterans Administration Suicide Prevention Program. Updates were made to the program website to keep information current and offer new resources.

c. Plan for the Coming Year
The Community Injury and Violence Prevention Group, an advisory group to the program, selected reducing suicide among working aged men as one of the priorities for intervention using federal CDC funds. The impact of suicide when the father dies by suicide is exceptionally detrimental to the entire family and stays with their children for life.

If funding resources are available, the program will continue to work with the MPCA to integrate evidence-based suicide prevention screening and assessment protocols and practices into more FQHCs to increase the possibility of reaching more at-risk primary care patients.

The MSPP plans to engage with the Veterans Administration and the Maine National Guard to reach active duty returning military and their families with information on resources available to them. The program plans to explore use of the "Family Acceptance Project" to reduce suicidal behavior among Lesbian, Gay, Bisexual, Transgender and Questioning youth and young adults.

The program will continue to provide gatekeeper training, training of trainers, awareness education, Transitions Lessons teacher training, clinician assessment training, an annual suicide prevention week event, and an annual suicide prevention conference.

MSPP will continue to promote the 24-hour crisis hotline, update the program website, and explore ways to improve the use of technology in an effort to reach new audiences, monitor

trends in suicide and self inflicted injuries among the Maine population, and distribute updated fact sheets and resource materials in a variety of formats.

State Performance Measure 2: *The percent of adult women reporting sexual assault or intimate partner violence within the previous 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					3.1
Annual Indicator			3.2	3.1	3.1
Numerator					
Denominator					
Data Source			Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3	3	2.9	2.9	2.8

Notes - 2011
2012 Data are not yet available. 2007, 2008 and 2010 data from Behavioral Risk Factor Surveillance System were used as an estimate.

Includes physical or sexual assault by an intimate partner within the past year, felt frightened for safety or safety of a family member due to threats from an intimate partner in the past year, or rape in past year.

Data from the BRFSS are weighted Therefore, a numerator and denominator are not presented for this measure.

Notes - 2010
2007, 2008 and 2012 data from Behavioral Risk Factor Surveillance System were used as an estimate.

Includes physical or sexual assault by an intimate partner within the past year, felt frightened for safety or safety of a family member due to threats from an intimate partner in the past year, or rape in past year.

Data from the BRFSS are weighted Therefore, a numerator and denominator are not presented for this measure.

Notes - 2009
Data Source: Behavioral Risk Factor Surveillance System

Combined estimate based on data collected in 2007 and 2008

Data include: Physical or sexual assault by an intimate partner within the past year, felt frightened for safety or safety of a family member due to threats from an intimate partner in the past year, any forced sex in past year.

Data from the BRFSS are weighted Therefore, a numerator and denominator are not presented for this measure.

a. Last Year's Accomplishments

Based on data from Maine's 2007, 2008 and 2010 BRFSS surveys, every year over 15,000 Maine women (3.1%) experience domestic violence (DV) or sexual assault (SA); 2.5% reported feeling frightened for their safety because of anger or threats by their partner, 1.6% were physically or sexually assaulted by an intimate partner, and 0.5% were raped in the previous 12 months. Of women who have been physically or sexually assaulted by an intimate partner, over half (57.2%) were injured as a result of the violence. In 2011, data from the CDC's National Intimate Partner and Sexual Violence Survey, indicated that 35.6% of women in the U.S. and 36.6% of women in Maine have ever been raped, physically assaulted or stalked by an intimate partner; 18.3% of women in the U.S. and 17.3% of women in Maine have ever been raped. In 2010, 45.1% of all assaults reported to police and 33.8% of homicides in Maine were related to domestic conflicts. In the same year, 389 rapes were reported to law enforcement. Between 2006 and 2010, the number of rapes reported to the police increased 14.4%.

In early 2010 the Maine CDC received funding from the Futures Without Violence to implement Project Connect (PC). The purpose of PC is to work with family planning and adolescent health providers to raise awareness and change policies and practice around screening for and responding to intimate partner violence, sexual violence, and reproductive coercion.

RESOLVE Chapter 99, LD 1105 passed in June 2009. This resolve required the Department of Education (DOE) to review its policies and rules regarding faculty training and student education on dating violence prevention for students in grades seven to twelve, and policies of the various school administrative units (SAUs). A Teen Dating Violence Prevention Workgroup met to draft a model school policy on dating violence with input from PC pilot schools and the Maine School Management. (The draft policy is attached)

Through PC, four SAUs were selected to increase collaboration with local domestic violence (DV) and sexual assault (SA) agencies and develop training plans to raise awareness and increase staff competency. These schools received training in Fall 2010 from Futures Without Violence. 33 school staff, administration, students, student resource officers and advocates were trained. The pilot schools also worked with the State work group to develop a model school policy to address and prevent DV and SA.

The Safe Families Partnership (SFP) was invited to the Fall 2010 School Nurse Institute to provide a training session. 22 of the 84 participants attended a session on DV/SA response and screening. The training covered; how to recognize the signs of adolescent relationship abuse, respond and report incidents of abuse in schools, and collaborate with local DV and SA agencies to receive further support within the school community.

Training was provided to the Maine Family Planning Association (FPA) clinic managers, School-based Health Centers and DV/SA advocate agencies on clinic policies related to DV/SA and developing collaborations with local DV/SA projects. In addition, all nurse practitioners and their specialists within family planning received a training on screening and responding to DV/SA, which included a cultural component. FPA participants were given reproductive health guidelines, DVD's, pregnancy wheels and safety cards. FPA purchased and disseminated 5,800 safety cards (2,900 teen cards and 2,900 adult cards) that included local advocate hotline and referral numbers.

A Women's Health Report was completed in FY11. Data on SA and intimate partner violence were included in this report. The full report can be found at: http://www.maine.gov/dhhs/mecdc/minority-health/womens-health/report.shtml

An attachment is included in this section. IVD_SPM2_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue work with policy workgroup.				X
2. Continue collaborating with local domestic violence/sexual assault projects and Maine Family Planning Association.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Four pilot schools completed projects that involved a student survey in one district to assess student attitudes, behaviors, and beliefs around dating violence, physical/verbal abuse, appropriate behaviors, and relationships. Another district sent members to school district policy meetings and local guidance counselor meetings to gather information about activities.

Training modules are being developed by The United Somali Women of Maine and the Maine Coalition to End Domestic Violence around cultural considerations. Trainings for these same groups are planned for late FY12.

Project Connect is part of a national project evaluation, therefore Maine will be involved in some components of the evaluation. Evaluation staff began surveying Family Planning clinic clients in February, 2012. Thus far, 65 women completed the baseline survey. Preliminary results revealed that 38.5% of these women had ever been the victim of intimate partner violence. Almost 90% reported that their health care provider talked with them about healthy and unhealthy relationships and 100% reported feeling that their health care provider cares about their safety. Follow-up over these women is currently underway and is expected to be completed by the end of July 2012.

c. Plan for the Coming Year

During FY13 the SFP will continue to make linkages between local DV/SA projects and Maine Family Planning Association.

The Title V Director will convene interested stakeholders to determine the role for Safe Families or a comparable organization in addressing sexual assault and violence against women as a public health priority; and assist Maine CDC in developing its workplan to support community efforts.

Work with Maine Principal's Association to adopt the model policy on dating violence. Several

schools have tailored the statewide dating violence policy draft to their own school and will seek to obtain passage of the policy in their district.

State Performance Measure 3: *Percent of students in grades 5-12 who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					25
Annual Indicator			26.8	26.8	32.4
Numerator					
Denominator					
Data Source			Maine Integrated Youth Health Survey	Maine Integrated Youth Health Survey	Maine Integrated Youth Health Survey
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	32	31.5	31	29.5	29

Notes - 2011
Data comes from Maine's 2011 Integrated Youth Health Survey (MIYHS).

Note change in measurement compared to 2009: In 2011, self-reported height and weight questions were removed from the 5/6 grade survey due to questionable validity of self-report data on height and weight from this age group. Measured height and weight were collected from 5th graders only. Therefore, this estimate reflects measured height and weight for 5th graders and self-reported height and weight from 7th-12th graders. No height or weight data were collected from 6th graders

Data from this survey are weighted, therefore a numerator and denominator for this measure are not presented.

Notes - 2010
Data comes from Maine's 2009 Integrated Youth Health Survey (MIYHS) grades 5-12. Data from this survey are weighted, therefore a numerator and denominator for this measure are not presented.

Notes - 2009
Data are based on student self-reported height and weight from Maine's 2009 Integrated Youth Health Survey, grades 5-12. Data from this survey are weighted, therefore a numerator and denominator for this measure are not presented.

a. Last Year's Accomplishments
Maine uses data from the Maine Integrated Youth Health Survey (MIYHS) to track this measure. The MIYHS was first administered in 2009 and is a comprehensive survey of the health of students in kindergarten, third, and fifth-twelfth grade. The high school version of the survey had four modules. One of these modules served as Maine's YRBS.

The most recent MIYHS data from 2011 indicated that 15.9% of high school students were overweight (85th-95th percentile of body mass index (BMI) and 12.9% were obese (>95th percentile). Among middle school students (7th and 8th grade), 20.l% were overweight and 15.5% were obese. Self-reported weight and height were not included on the 2011 MIYHS due to the questionable accuracy of the data, but measured height and weight were obtained from 5th graders. Among fifth graders in Maine, 19.6% were overweight and 23.8% were obese. Therefore, more than 1 in 3 (32.4%) Maine children in grades 5 and 7-12 are above a healthy weight. Maine's percentages of obese and overweight high school students in 2011 were not statistically different than the 2011 U.S. percent based on the YRBS. The Healthy People 2020 goal for obesity among adolescents age 12-19 is 16%. The percentage of overweight and obese high and middle school students in Maine has not changed significantly between 2001 and 2011.

In FY11, after an eighteen month planning process, a Request for Proposals (RFP) for essential prevention services for the Healthy Maine Partnership Initiative (HMP) was issued. There were several objectives related to physical activity and nutrition in schools and all 31 school health coordinators are required to implement objectives that focus on improving school wellness policies that advocate for increased physical education time in their schools; increased physical activity before, during and after the school day; and promotion of after school activities at school facilities. Implementation began in July 2011; progress on objectives will be reported using an online tracking system.

The Coordinated School Health Program (CSHP), in line with its new federal CDC workplan, provided $ 5,000 mini grants to four new sites under the coordinated school health model. CSHP focused on low performing schools and those most likely to have higher obesity rates and high risk behaviors. Previously seven priority schools were awarded grants to assess current health efforts in their schools, plan new priorities, and focus policy and environmental change to improve student health. All priority schools were required to select an evidence-based intervention to increase physical activity among students.

Through a successful American Recovery and Reinvestment Act, Communities Putting Prevention to Work application the Physical Activity, Nutrition and Healthy Weight Program (PAN-HW) brought $4.28 million to Maine (1 of 40 states) in the Fall of 2010, a large portion of which were community level funds. Three of the funded schools drafted model wellness policies that increased physical activity during the school day and laid out standards and regulations around foods offered in schools, i.e.; eliminating unhealthy foods as a classroom reward and as a fundraising tool, and eliminated withholding recess as a punishment for students.
The Department of Education (DOE) held a training on the Health Education Curriculum Analysis Tool (HECAT) at the annual Maine Association for Health, Physical Education, Recreation and Dance Conference. This tool, developed by the federal CDC, focuses on analyzing a curriculum to ensure those adopted by schools are comprehensive. Areas addressed in HECAT include healthy eating and physical activity and personal health and wellness.

In June 2011 LD 1558, "Resolve, To Study Allocations of the Fund for a Healthy Maine" was passed. This resolve established a commission tasked with reviewing whether allocations of the fund were properly aligned with the State's current public and preventive health priorities, strategies and goals and recommending adjustments to allocations as necessary. A significant recommendation of the Commission resulted in LD 1855 "An Act Regarding the Fund for a Healthy Maine's Prevention, Education and Treatment Activities Concerning Unhealthy Weight and Obesity" to create a separate budget for prevention, education and treatment activities concerning unhealthy weight and obesity to be used beginning in fiscal year 2014-2015.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Enhance Maine's nutrition and physical activity surveillance infrastructure.				X
2. Continue monitoring trends in overweight through the Maine Integrated Youth Health Survey.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A Statewide Work Group convened in 2008 to look at ways to strengthen Farm-To-School (F2S) efforts in the State, launched a F2S Network in FY12 to provide local support to partners and to work with school food service programs to determine how to incorporate the F2S effort into their federally regulated programs. Several AmeriCorps volunteers are working with schools to improve nutrition through F2S and to institute school gardens as a nutrition and education tool.

The Active Living, Healthy Eating, Healthy Weight Plan is in final draft form. Much of the emphasis of this work was focused on improving physical activity and nutrition of youth in grades 5-12. We anticipate the plan to be completed in late FY12. Obesity among adolescents also emerged as a Healthy Maine 2020 measure thus ensuring continued commitment to address this issue.

The Maine CDC, Division of Population Health received a 5-year Community Transformation Grant under which workgroups in the Public Health Districts will be developing nutrition policies and increasing physical education for both K-12 and childcare providers. All public health districts received funds beginning in January 2012.

The Maine Commissioner of Education worked to develop a strategic plan and included coordinated school health and wellness as a primary component of the plan. This is significant in terms of supporting a healthy school environment for learning and academic achievement in that nutrition and physical activity are included.

c. Plan for the Coming Year
Although the rates of obesity and overweight in Maine have not increased significantly over the past few years, the high rates point to a need to address the issue before the health consequences of excess weight cause lasting problems.

As a result of the Commission to Study the Fund for a Healthy Maine, LD 1855, "An Act Regarding the Fund for a Healthy Maine's Prevention, Education and Treatment Activities Concerning Unhealthy Weight and Obesity" was passed in March 2012; an indication that our legislators recognize this as an issue of public health importance.

Community Transformation Grant funds allocated to the Public Health Districts requires that they work with 30% of their schools on nutrition and physical activity policies. Each district will identify those schools they wish to participate and have them focus on physical education minutes and nutritional offerings both food and beverage.

The Coordinated School Health Program will continue to work with School Health Coordinators to

improve wellness policies and continue to develop a wellness tool kit for use at the local level and expand professional development events to broaden the reach of coordinated school health as a model beyond those districts that receive funding.

DOE will promote its Key Concepts curriculum development tool to health educators, school health coordinators and other school personnel which support nutrition education, eating disorder prevention, and physical activity. DOE will also explore options to provide professional development to teachers in a cost effective manner; i.e. webinars and video conference.

The economic landscape continues to look challenging for the next year with programs being asked to do more with less, both funding and staffing. There is great concern on the part of programs in being able to meet deliverable requirements with staffing shortages and an inability to fill positions.

State Performance Measure 4: *The rate of unintended births among women less than 24 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					54
Annual Indicator		54.5	64.7	64	64
Numerator					
Denominator					
Data Source		Maine PRAMS	Maine PRAMS	Maine PRAMS	Maine PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	63	62	61	60	59

Notes - 2011
Data are from the 2010 PRAMS survey. 2011 PRAMS data are not yet available.

Notes - 2010
Data are from the 2010 PRAMS survey.

Notes - 2009
Data are from the 2009 PRAMS survey.

a. Last Year's Accomplishments
According to the most recent data from Maine's Pregnancy Risk Assessment Monitoring System (PRAMS), almost two-thirds (64.0%) of births to Maine women less than 24 years of age in 2010 were unintended. The percent of unintended births among this age group had been decreasing until 2008 when 54.5% of births were unintended. However, the proportion of unintended births increased to 64.7% in 2009 and this increase was sustained in 2010. The increase was driven by the percent of new mothers under age 20 who reported that their birth was unintended; in 2010, 89.4% reported the birth was unintended. This is the highest that Maine has seen among this age group for the past five years.

The Maine CDC received $250,000 in Teen Pregnancy Prevention funds from the federal government's Personal Responsibility Education Program (PREP) in FY11. The funds are being used to address teen pregnancy and STD prevention. An initial stakeholder meeting revealed that

the 18-19 year old population in Maine had higher pregnancy rates, unintended pregnancy rates, and were more difficult to reach. Maine's Family Planning Association and Jobs for Maine Graduates, a program established by the Maine State Legislature to help students who are facing challenges to education and to help them achieve success in school and beyond, partnered to train in and implement PREP using an evidence-based curriculum "All4You"; a skills-based, HIV/AIDS, and pregnancy prevention curriculum developed for students in alternative schools. The 14-session program is comprised of two components: classroom-based lessons and service learning projects at community organizations.

Approximately 45 students from eight schools are participating in the project to date. Several foster children are among those participating in the program. This is a population we have had difficulty reaching and hope that through this program we will reach more adolescents and will begin to see the number of pregnancies decrease.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family planning clinical services.	X			
2. Community-based pregnancy prevention using evidence-based programs.		X	X	X
3. Continue to monitor via PRAMS.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Despite reductions in existing resources and continued success of current strategies, we continue to examine our strategies and compare them to the growing research base on effective practices. Because of the greater consequences for younger pregnant and parenting teens, and the importance of early knowledge and skill development that carries into young adulthood, the majority of unintended pregnancy prevention resources continue to focus on school-aged youth.

Through the PREP initiative we are gradually reaching young adults in non-traditional settings who may be at greater risk and hope to see a decrease in unintended pregnancies in this population.

Through the Project Connect Initiative a Cultural Consideration Training was held in Spring 2012 for Family Planning Association clinicians, School-based Health Center clinicians, DV/SA advocates and the Project Connect leadership team to provide tools to assist in addressing SA, intimate partner violence and reproductive coercion which are associated with unintended births.

c. Plan for the Coming Year

Funding reductions and increased health care costs preclude any increases in services and will continue to challenge our ability to maintain current levels of services. This measure will continue to be one of Maine's State Performance Measures over the next three years. We anticipate a decline in this measure over time. However, we acknowledge that proposed budget cuts to family planning services may challenge our ability to make significant progress on this measure.

We will be tracking this measure in years to come as Healthy Maine 2020 has an objective to "increase the proportion of births that are intended".

The Jobs for Maine Graduates follows their students for one year after they leave the program so we are hopeful that they will continue to use the PREP "All4You" curriculum beyond the end of the grant period to assist us in tracking this population over time.

State Performance Measure 5: *The hospitalization rate (per 10,000) of unintentional poisonings among children and youth age 0-24 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					1.9
Annual Indicator			2.0	2.0	2.0
Numerator			76	76	76
Denominator			389529	389529	389529
Data Source			Maine Hospital Discharge Data	Maine Hospital Discharge Data	Maine Hospital Discharge Data
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.7	1.6	1.5	1.4	1.3

Notes - 2011
2011 hospital discharge data are not yet available. 2009 data are used as an estimate.

Notes - 2010
Data are not yet available for 2010. Data from the 2009 Maine Hospital Discharge Dataset were used as an estimate.

Notes - 2009
Data are from Maine's 2009 Hospital Discharge Dataset and represent children who are Maine residents aged 0-24 who were hospitalized, but did not die from an unintentional poisoning.

a. Last Year's Accomplishments
This measure was selected because it is one of the leading causes of hospitalization in Maine and the Maine Injury Prevention Program (MIPP) has identified unintentional poisoning as one of its unintentional injury priority areas. Among children aged 1-4, unintentional poisoning is the second leading cause of injury-related hospitalizations and the third leading cause of injury-related hospitalizations among infants under age 1 year. In 2009, there were 76 hospitalizations for unintentional poisoning among youth aged 0-24, a rate of 2.0 per 10,000. 2010 hospitalization data is not yet available.

Unintentional poisoning has been increasing in the state and MIPP has been working with the Northern New England Poison Control Center (NNEPCC) and the Maine Office of Substance Abuse to examine and address the problem. The NNEPCC reports to the MIPP on calls received by the center; calls are tracked by age and type of call and subsequent education delivered as a result of the call.

The MIPP is the fiscal agent for state funding provided to the NNEPCC. The NNEPCC educator conducts outreach education on such topics as inhalant prevention, unintentional poisoning, home safety and prescription medication abuse. Audiences include educators, Healthy Maine Partnerships, Native Americans, Spanish speaking community, and child care providers.

Through a one-year Request for Proposals, the MIPP funded ten communities to conduct one injury prevention intervention or injury prevention policy within each of the states' Public Health Districts. Two of the communities are addressing prescription medication. One intervention, "The Diversion Alert Program" is a collaborative between law enforcement and primary care physicians (PCP); when there has been an arrest for prescription medication violation law enforcement communicates with PCPs so they can monitor whether the individual is shopping for doctors or attempting to divert medications not prescribed to them. The project has been very successful and is being considered by the Maine Drug Enforcement Agency to pilot in three other counties in the State. Another very successful project, "Don't Flush Me Program" is an effort by law enforcement to raise awareness about and encourage Maine residents to give back prescription medications they do not use or that have expired.

Maine's Home Visiting Program conducts safety assessments every six months and provides information to families related to poisoning. Home visitors share critical safety information based on any concerns that are identified. At subsequent visits, home visitors check in to make sure safety improvements have been made. Over 90% of families are following recommended safety practices at follow-up visits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with law enforcement, schools, hospitals, federally qualified health centers and other stakeholders to increase awareness of the high rate of prescription abuse among teens.			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Poisoning continues to be one of the four leading causes of injury and death in Maine and is one of the Healthy Maine 2020 indicators. The MIPP continues to fund the NNEPCC to conduct outreach education on the issues of bath salts and prescription medication misuse and abuse, as well as basic poison prevention education. Office of Substance Abuse staff and other organizations participate on the MIPP Community Injury and Violence Prevention Group and routinely share information on statewide prevention activities such as medication give back programs.

The MIPP is working with the NNEPCC Outreach Educator to develop a home safety tool kit for children birth to eight years old.

The MIPP held an injury conference in July 2011 that included two presentations on poisoning and participated in four home safety conferences in which poisoning was addressed. Participants

included landlords, health inspectors, housing authorities and Maine Healthy Homes Program staff.

The Department of Education added an injury prevention section in its Linking Key Concepts to the Maine Health Education Standards, a document that links key education and prevention concepts to the health education standards and performance indicators outlined in the Maine Learning Results. Several concepts are directly linked to poisoning or unintentional poisonings at all grade levels.

c. Plan for the Coming Year

Staffing and budget constraints have hampered program capacity to provide educational outreach on poisoning. However as funding permits, the MIPP will work with the NNEPCC Outreach Educator to identify activities specific to home safety (birth to 8 years) to address.

Through new Federal Centers for Disease Control and Prevention Grant funds the MIPP will identify four interventions; two programmatic and two policy. MIPP is working with the Office of Substance Abuse and its' Healthy Maine Partnership sites to implement strategies addressing prescription medication misuse by enhancing the participation of primary care physicians to utilize the Prescription Monitoring Program.

State Performance Measure 6: *The percent of women with depressive symptoms receiving medication or treatment for a mental health or emotional condition by a doctor or other healthcare provider.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					63
Annual Indicator				62	62
Numerator					
Denominator					
Data Source				BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	64	65	66	67	68

Notes - 2011

2011 BRFSS data are not yet available. Data for this indicator are from Maine's 2010 Behavioral Risk Factor Surveillance System (BRFSS). The measure represents the percent of adult women who report symptoms of moderate or severe depression on the PHQ-8 who also report that they are currently taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.

Notes - 2010

Data for this indicator are from Maine's 2010 Behavioral Risk Factor Surveillance System (BRFSS). The measure represents the percent of adult women who report symptoms of moderate or severe depression on the PHQ-8 who also report that they are currently taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.

a. Last Year's Accomplishments

This measure was selected because the determinants of mental illness can be biological, social, and neurological. They can include experiences with violence as an adult or child, stressful life events, and lack of social support. It is critical that health care providers screen for signs of mental distress and help patients receive needed treatment. Research suggests that primary care providers can play a critical role in detecting and treating depressive symptoms. This measure will help us assess whether women who are struggling with depression are receiving care. Based on 2010 data from Maine's BRFSS, 10% of adult women in Maine reported recent moderate or severe symptoms of depression. Of these women, 62% were taking medicine or receiving treatment from a doctor for any type of mental health condition or emotional problem.

During FY11, Maine received Futures Without Violence (FWV) funds to assist in raising awareness in preventing domestic violence (DV) and sexual assault (SA). The Maine CDC worked with the Maine Coalition Against Sexual Assault (MECASA), Maine Coalition to End Domestic Violence (MCEDV), Family Planning Association (FPA) and School-Based Health Centers (SBHC) to conduct a training on such topics as: reproductive health integrated assessment; referral, confidentiality and reporting; how to address unique barriers/issues of patients from tribal, immigrant, migrant, or disabled communities; and unique considerations for adolescents in family planning settings and resources available in the state. Training participants received reproductive health guidelines, DVDs, pregnancy wheels and safety cards (cards attached). FPA purchased and disseminated 5,800 cards (2,900 teen cards and 2,900 adult cards) which included local advocate hotline referral numbers. As a result of this training FPA updated their clinical standards to incorporate depression screening and responding.

SBHC staff attended a webinar in February 2011 that covered detecting unhealthy student relationships, promoting healthy student relationships, and using a collaborative care model. SBHCs administer a PHQ2 and if there is a positive they administer a PHQ9.

The Division of Population Health has also identified those programs that connect with women prenatally and postpartum to include PHQ2 for screening. Public Health Nursing (PHN) began using the Edinburgh Screening Tool with all postpartum clients starting in May 2009. All five Community Health Nursing (CHN) agencies, as an extension of PHN MCH efforts, also use the Edinburgh Screening Tool.

During FY11, 305 PHN clients received 425 Edinburgh-specific interventions. 91.5% of these clients were assessed after childbirth and 8.5% before. An additional 764 clients received 4,364 non-Edinburgh assessment interventions such as nursing assessment of "signs/symptoms-mental/emotional" that were targeted to mental health symptom surveillance. 95.9% of these clients were assessed after childbirth and 4.1% before.

During FY11 a Women's Health Report that examined the factors that contribute to women's health and well-being was completed. The report includes information on the mental health status, substance use and abuse, and injury of women.

An attachment is included in this section. IVD_SPM6_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with the Office of Health Equity and the Community Caring Collaborative on LAUNCH and begin replicating effective practices demonstrated by LAUNCH to other areas of the state.		X	X	X
2. Begin implementation of the women's mental health strategy mapping action plan.			X	X
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During Year three of FWV funding, the Division of Population Health (formerly Division of Family Health) will work with the MCEDV, MECASA, FPA and other Project Connect advisory partners; the year three goal is to enhance the capacity and knowledge of Maine's SBHC and family planning programs to identify and respond to intimate partner violence (IPV) including reproductive coercion (RC) in the clinical setting and promote healthy dating relationships through increased knowledge and policy development, risks for unintentional pregnancy, HIV/STI to improve adolescent health and safety outcomes.

In late FY11, we embarked on a strategy mapping process with key stakeholders to identify goals and activities to address this state performance measure. A significant outcome of this process was including representatives from adult mental health as well as private sector psychologists in planning mutual strategies to address this priority. In partnership with those who collaborated on this process we will begin implementation of the action plan. We will also widely disseminate the action plan with other interests, both public and private.

The bridging component of the Linking Actions for Unmet Needs in Children's Health project looks at the physical and mental health of children birth-eight years. This project allows for treatment of parents identified with mental health issues as their health impacts that of their child.

c. Plan for the Coming Year

Much effort was expended by multiple groups in developing the women's mental health priority plan therefore we want to acknowledge their work both past and future around this very important issue. This process has enabled the Division of Population Health to connect with the Office of Adult Mental Health staff within the DHHS as well as private sector providers around a common issue. We hope, through the Perinatal Outreach Education and Consultation Coordinator, to gain access to hospital grand round agendas for psychiatrists engaged in our priority strategy mapping to conduct women's mental health training. In addition we will seek opportunities to allow these groups to continue working together so as to maintain these critical connections.

We will monitor and share with partners, funding opportunities as potential resources to assist our partners in implementing some action plan activities.

During FY12 a Maine CDC re-organization resulted in the Family Health and Chronic Disease Divisions merging into a new Division of Population Health (DPH). This change will allow the Women's Health Coordinator to focus solely on women's health as Teen and Young Adult Health activities are transitioned to others within the DPH.

State Performance Measure 7: *The rate of substantiated cases of child abuse and neglect assessed by Maine's Office of Child and Family Services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010	2011

Data					
Annual Performance Objective					13.9
Annual Indicator			14.0	8.0	8.0
Numerator			3809	2179	2179
Denominator			271176	271176	271176
Data Source			ACYF Child Maltreatment Report 2009	ACYF Child Maltreatment Report 2010	ACYF Child Maltreatment Report 2010
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	13.8	13.7	13.6	13.5	13.3

Notes - 2011
Data are from 2010 ACYF Child Maltreatment Report (see citation below). The numerator represents the number of unique children with a substantiated report of child maltreatment in 2010. Population denominators are based on children <18 years of age as of July 1, 2009. 2010 data were not yet available.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). Child Maltreatment 2010.

Notes - 2010
Data are from 2010 ACYF Child Maltreatment Report (see citation below). The numerator represents the number of unique children with a substantiated report of child maltreatment in 2010. Population denominators are based on children <18 years of age as of July 1, 2009. 2010 data were not yet available.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). Child Maltreatment 2010.

Notes - 2009
Data are from 2009 ACYF Child Maltreatment Report (see citation below). The numerator represents the number of unique children with a substantiated report of child maltreatment. Population denominators are based on children <18 years of age as of July 1, 2009.

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administrationon Children, Youth and Families, Children's Bureau. (2010). Child Maltreatment 2009. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can

a. Last Year's Accomplishments
This measure was selected because adverse childhood experiences (ACE), especially child abuse and neglect and exposure to domestic violence (DV), can have serious long lasting affects on an individual's physical and behavioral health and well being. The data for this measure are collected by Maine's Office of Child and Family Services (OCFS) and reported to the Administration for Children and Families. In 2010, there were 15,578 referrals to Maine's child protective agency, the OCFS. Of these referrals, 2,179 were determined to be substantiated

cases of abuse; these cases represented 3,269 unique children. The highest rates of abuse were among children aged 1 year and younger. 85% of the perpetrators were parents. Of the different types of maltreatment identified, 76.9% were neglect, 39.9% psychological maltreatment, 16.1% physical abuse, and 6.8% sexual abuse. By reducing Maine children's exposure to violence, we will decrease the number of child abuse cases assessed by the state for maltreatment, decrease the number of children in out of home care, improve rates of infant mortality and improve the health of the people of our state.

Strengthening Maine Families (SMF) led by the Maine Children's Trust (MCT) tailors the national, evidence based Strengthening Families approach, working with child care providers to recognize and appropriately respond to signs of stress in families and work with their families to develop and strengthen protective factors such as offering concrete support in times of need and helping parents understand and bolster their children's social emotional development and well-being. The approach helps prevent child maltreatment.

The SMF Project has developed a website for child care providers and partnered with the University of Southern Maine, Maine Roads to Quality, and the National Alliance of Children's Trust and Prevention Funds to create a curriculum to promote the use of the protective factors and prevent child abuse. A full 30-hour core training as well as a 15-hour on line training will be available.

Maine's OCFS was one of nine states that received funding from a Federal Maternal, Infant, and Early Childhood Home Visiting Expansion Grant. Maine is using funding from the U.S. Department of Health and Human Services' Health Resources and Services Administration to expand and enhance Maine Families Home Visiting (MFHV), an evidence-based home visiting program designed to improve maternal and child health, reduce child maltreatment, and increase school readiness. This grant will increase access to the program to all families in Maine, and ensure that high risk families will have better access to specialized services through formal community based collaboration. Home visiting rates of child maltreatment for those participating are approximately half that of the rest of the state.

The MCT Safe Sleep Coalition has undertaken efforts around increasing awareness of safe sleep practices for infants, pursuing public service announcements and providing education to nurses, physicians, and other neonatal care providers. Successful outcomes of the Coalitions work include: branding and distribution of Safe Sleep videos to every birthing facility in the state for use with every new birth; and implementation of a Kids for Cribs Chapter housed at Maine Medical Center (MMC) in Portland that provides cribs for those families that otherwise could not afford them and would have unsafe sleep situations. Approximately 100 cribs have been purchased and distributed through the MFHV network.

Dr. Jen Hayden with the Barbara Bush Children's Hospital and the MMC Perinatal Outreach Consultant provided on-going safe sleep trainings at grand rounds to medical professionals around the state as well as some child welfare professionals and child care centers during FY11.

The Maine Legislature took notice of the federal initiative to promote evidence based home visiting programs as a child maltreatment prevention strategy. LD 1504 requires the Maine DHHS to continue its investment in a statewide home visiting network of services and use the home visiting Needs Assessment to inform enhancement of services in high risk communities. The needs assessment process helped shed light on effective partnering among PHN, CHN, and MFHV, and made many stakeholders aware of the opportunities for more efficient and effective service delivery for young families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Strengthening Maine Families.			X	
2. Maine Families Home Visiting.	X			X
3. Abusive Head Trauma/Shaken Baby Syndrome Workgroup.			X	
4. Safe Sleep Coalition.		X		
5. Maine Children's Growth Council Parent Education Initiative.				X
6. Public Health Child Welfare Liaison.				X
7. Partner with the Maine Children's Trust on evidence-based parent education.				X
8.				
9.				
10.				

b. Current Activities

Through the Period of Purple Crying (POPC) Initiative, the implementation team, convened by the MCT identified the need for deeper engagement with the pediatric medical community to offer follow-up reinforcement of the initial information and messaging. Presentations are scheduled at conferences through the end of FY12 in an effort to engage pediatricians and provide them with materials to supplement the work and the messaging of the MCT. Expansion of materials includes a new training component that the MCT will distribute to all hospitals and home visitors. This new training component offers a 'how to sooth your baby' piece. The training is offered online through the National Center on Shaken Baby Syndrome at: www.dontshake.org. The MCT convened implementation team, supplements the online training at the state level to those seeking additional assistance on delivering the POPC.

c. Plan for the Coming Year

The SMF curriculum was piloted during FY12 and the State plans to offer a shortened 15-hour online version that will enable the State to offer elective credits thus allowing the SMF to reach a broader network of child care providers and other professionals working with families and children.

Other activities planned for FY13 include: offering the Safe Sleep training statewide to child welfare workers and purchase and distribute additional cribs for kids.

State Performance Measure 8: *The percent of children aged 12-36 months enrolled in Medicaid who have had a claim for a social, emotional or behavioral developmental screening test.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Data Source			Medicaid Claims	Medicaid Claims	Medicaid claims
Is the Data Provisional or Final?					
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	58	59	60	61	62

Notes - 2011
Data are not currently available, but we will work with Maine's Office of MaineCare Services to obtain baseline data during FY12.

a. Last Year's Accomplishments
According to 2008 US CDC estimates, about 1 in 88 children have been identified with an autism spectrum disorder. (http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6103a1.htm?s_cid=ss6103a1_w) In 2009, MaineCare paid claims for more than 4,156 Maine residents diagnosed with Pervasive Developmental Disorders (PDD); the largest number in the six-12 years age group. (http://www.maine.gov/dhhs/reports/autism_spectrum_disorders_report_3-11.pdf) Maine chose this measure to ensure that all children with autism spectrum disorder/developmental disabilities (ASD/DD) are identified as soon as possible so that the child and family can receive the full benefit of early intervention services and supports. We will work with our Medicaid agency over the next year to obtain baseline data for this measure.

In 2010 the Maine CDC Children with Special Health Needs (CSHN) Program applied for and was awarded a three-year State Autism Implementation Grant (AIG) funded under the federal Combating Autism Act Initiative to improve health outcomes for individuals with autism and other PDDs through early identification, and provision of effective and coordinated treatment within a comprehensive medical home. The PDD Early Identification Workgroup, established in 2007 and staffed by the Maine Developmental Disabilities Council, is implementing the grant activities.

FY11 activities included: collaborating with developmental pediatricians, families, community providers and the Autism Society to create a 30-minute digital video disk (DVD) that provides ongoing sustainable training on first signs of autism; how to administer and score the Modified-Checklist for Autism in Toddlers (M-CHAT), Part 1; how to administer and score the M-CHAT, Part 2; how to talk to families about screening; a brief overview of other medical issues; and a brief overview of the Ages and Stages Questionnaire (ASQ) developmental screen. In addition to the DVD a booklet was developed that contains pre-vetted training examples. The intent is to have a complete packet on how to conduct the training. 70 physicians attended hospital grand rounds across the state where universal screening was promoted. The Autism Society of Maine trained 42 WIC staff on the first signs of ASD so they can assist families of children who are displaying warning signs of autism to get the necessary screening and evaluation.

AIG staff learned from both families and professionals that duplicative evaluations are sometimes conducted with little communication between medical specialists and early intervention professionals, as well as, uncoordinated service plans for children. To address this issue, the AIG supported two pilots, Child Development Services Reach and Maine Medical Partners, to develop quality improvement protocols to improve communication and coordination between case managers and physicians. The goal of the new protocols is to map comprehensive, coordinated early intervention therapy that spans both educational and medical systems.

The initial M-CHAT modules have been constructed within Facilitating Autism Screening and Treatment (FAST) using the ChildLINK database. The FAST will provide a portal for home visitors, Head Start, and Public Health Nurses to communicate to primary care providers (PCP) about screenings. PCPs will also be able to use FAST to refer children for evaluation and services.

In February 2010, Maine, in partnership with the State of Vermont, was awarded a five-year child health quality improvement grant to improve health outcomes for Medicaid eligible children, thereby improving their timely access to quality care. One of the Children's Health Insurance Program Reauthorization Act (CHIPRA) measures is to increase both general developmental screening and screening for autism. The AIG has engaged in a collaborative effort with the Improving Health Outcomes Committee (IHOC) to have learning sessions with physicians. These Learning Sessions will focus on best practices for improving early identification of developmental

disabilities, autism, lead and anemia by increasing screening in Maine and how quality improvement work is most successful when built on a foundation of Patient Centered Medical Home guiding principles and core expectations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide ongoing sustainable training for PCPs and other medical professionals on universal screening for autism.				X
2. Provide ongoing training for providers, CDS case managers and others who work with individuals with ASD on care coordination.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To reduce barriers that currently exist for families accessing care for their children with ASDs, the medical home portion of the CHIPRA grant is being aligned with the AIG grant. In August of 2011 a seminar was held to bring together pediatricians and developmental specialists to identify the "current state" of care coordination for children with ASD taking place in specialist's offices and determine what could/should be utilized by all general practitioners. The outcome of this day provided the foundation for care coordination for two medical home pilots for autism.

Maine is collaborating with the University of Massachusetts Learning and Developmental Disabilities Evaluation and Rehabilitation Services (LADDERS) to create a framework for care coordination to pilot a medical home for autism that was developed by Wisconsin.

c. Plan for the Coming Year

Maine will collaborate with Vermont to plan and develop a document that outlines how to provide developmental screening to non English-speaking individuals and will work with the Barbara Bush Children's Hospital at Maine Medical Center in Portland and Husson Pediatrics in Bangor to pilot.

The AIG will expand the training curriculum developed by Maine Medical Partners to reach additional primary care providers so that more primary care practitioners will have knowledge and tools to provide quality healthcare for children with ASD. We hope to have the five developmental pediatricians who have already been trained in the curriculum provide the training to the primary care providers in their communities. In addition, we hope to make an online version of the training available to medical office staff to enhance their ability to support successful medical appointments for children with ASDs.

The AIG will support the Maine Parent Federation to present a curriculum that provides information to families about a medical home, what it is and how to engage in a medical home.

Maine's Title V program will work with MaineCare to receive baseline data for this measure and

determine how to best track this indicator over time.

E. Health Status Indicators

The Health Status Indicators (HSI) provide key information on several risk factors that are among the leading causes of morbidity and mortality in Maine. The data from these indicators have been used in public documents, state health plans, and direct efforts of public health programs in the state. We rely heavily on these indicators as measures of the quality and capacity of our health systems for pregnant women and children and these measures continue to be monitored on an ongoing basis.

#01A. The percent of live births weighing less than 2,500 grams.

Low birth weight is one of the leading causes of infant mortality in the state. Maine's rates of low birth weight and very low birth weight have not changed substantially in the past 4-5 years, but they have increased since the early 1990s. Maine has one of the lowest low birth weight rates in the U.S. In 2011, 6.7% of infants (n=855) were born weighing less than 2,500 grams.

The Title V agency currently has access to birth certificate data through Maine's Data, Research and Vital Statistics Program (DRVS). DRVS is currently transitioning to an electronic death registration system and is in the beginning stages of developing a modern electronic birth certificate (EBC) system that will use the 2003 U.S. standard birth certificate; the existing EBC system is approximately 17 years old. DRVS is working with offices and programs across the Maine Department of Health and Human Services (DHHS), as well as other Executive Branch agencies to develop and fund the new EBC and anticipates a 2013 rollout.

Data on this indicator were used to help pass legislation to initiate a Maternal, Fetal Infant Mortality Review Panel in the state. This panel is reviewing cases of infant deaths in order to examine how system change can improve care, reduce the incidence of low birth weight and premature babies, and decrease infant mortality and morbidity.

The Maine Families Home Visiting Program (MFHV) encourages enrollment during the prenatal period to increase the adequacy of prenatal care and decrease smoking during pregnancy, two of the risk factors for low birth weight births. Almost 94 percent of expectant mothers enrolled in MFHV received at least adequate prenatal services. As part of the new funding for home visiting, states are required to develop benchmarks for their home visiting program that will be tracked over the funding period. Maine's benchmarks include: early and adequate prenatal care, reduced smoking during pregnancy, screening for domestic violence, and receipt of needed services. These are factors that could promote healthier pregnancies and reduce low birth weight. In 2010, Maine received a competitive grant to expand its home visiting program to serve more families and provide enhanced services to those at highest risk for poor birth outcomes. The new enhanced services portion of Maine's home visiting program will be modeled after Maine's Project Launch initiative. In 2008, Maine's Title V program received a 5-year SAMHSA Project LAUNCH Grant to improve child serving systems through collaboration and partnership. The grant is supporting a diverse group of organizations and community members in Washington County, the most impoverished county in Maine. During the last decade, there has been an epidemic of synthetic opiate abuse in this county, resulting in significant numbers of preterm births, low birth weight infants, and prenatal substance exposure rates. Washington County's Community Caring Collaborative is working together to build systems that support prevention and intervention services for families.

Maine's WIC program also promotes adequate prenatal care and promotes good nutrition during pregnancy. During FY10, over 27,000 families in Maine were served by WIC.

#01B. The percent of live singleton births weighing less than 2,500 grams.

There were 12,700 births and 12,287 singleton births to Maine residents in 2011. Of singleton births, 5.2% (n=641) were low birth weight compared to 6.7% of all births. Low birth weight among singleton births is one of the outcomes included in Maine's Environmental Health Tracking Network. (http://www.maine.gov/dhhs/eohp/epht/) Data on this indicator are presented by year, sex, public health district and county. (See HSI #01A for more information on activities aimed at reducing low birth weight in Maine.)

#02A. The percent of live births weighing less than 1,500 grams.

In 2011, there were 144 babies in Maine born weighing less than 1,500 grams; 1.1% of all births. Since 1999, Maine's VLBW rate has been between 1.0% and 1.3%. Maine's Perinatal Outreach Coordinator coordinates transport conferences across the state throughout the year to train providers about proper transport of high risk infants and mothers.

#02B. The percent of live singleton births weighing less than 1,500 grams.

Of the 12,287 singleton infants in the state, 116 (0.9%) were born weighing less than 1,500 grams.

(See HSI #02A for more information.) The percent of singleton low birth weight babies born in Maine each year has not increased or decreased substantially since at least 1994.

#03A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Due to small numbers, 5-year average rates are reported for this indicator. Between 2006-2010, there were 68 unintentional injury mortality deaths among children aged 14 years and younger in Maine, a rate of 6.1 per 100,000. The majority of these deaths were due to motor vehicle crashes (see HSI #3B, #3C for more information). Between 2005-2009, motor vehicle traffic crashes were the leading cause of injury death for children between the ages of 5-14 years. Among children between 1-4 years of age, the leading cause of injury death was drowning, followed by unintentional suffocation, fire/burn injuries, and motor vehicle crashes. Among children under age 1, the leading cause of injury death was unintentional suffocation. The Maine Injury Prevention Program (MIPP) is working to reduce deaths due to unintentional injury through efforts to reduce motor vehicle crashes and unintentional poisonings.

HSI data on unintentional injury in Maine were used to secure funding from the Federal Centers for Disease Control and Prevention to improve Maine's injury surveillance capacity. These data have also helped to increase collaborative efforts between Maine's Injury Prevention Program (MIPP) and Maine's Bureau of Highway Safety, maintain funding for a car seat safety program, and successfully tighten restrictions on teen drivers' licenses. Unintentional injury data were incorporated in Healthy Maine 2010 and will be part of Healthy Maine 2020, public documents that outline the health objectives for Maine residents.

Unintentional injury was also selected as one of Maine's ten MCH priorities for 2010-2015 based on the 2010 five-year Comprehensive Strengths and Needs Assessment. A state performance measure addressing unintentional poisoning among youth under age 24 was created as the result of the selection of this priority.

#03B. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged
14 years and younger.

Rates of unintentional injury and motor vehicle crash deaths among youth have not changed significantly in recent years in Maine. Between 2006-2010, there were 20 deaths due to motor vehicle crash injuries to children age 0-14, a rate of 1.8 per 100,000. Unintentional injuries, specifically motor vehicle crashes, are the leading causes of death among Maine youth, but rates in Maine have been decreasing since 2003/2004. Based on this data, the MIPP has identified motor vehicle crashes as a priority in their program plan and is expanding their efforts to address the issue. The MIPP is now coordinating Maine's CODES (Crash Outcome Data Evaluation System) Project. The CODES Project links hospitalization and death certificate data with police crash data to examine health outcomes related to motor vehicle crashes. The linked dataset will be complete in July 2012.

Maine's Bureau of Highway Safety (BHS) is now the lead agency for Child Passenger Safety (CPS) efforts in the state, but MIPP continues to partner with BHS and distribute CPS educational materials. Child Passenger Safety is part of Maine BHS' strategic plan, which was developed by the Maine Transportation Safety Coalition.

The annual Child Passenger Safety meeting was held in September 2010 to recognize the work of CPS technicians and provide additional opportunities for training.

Tall Pines Safety Resource Center is the lead agency for Safe Kids Maine, a nonprofit that provides outreach and safety information to the public to prevent unintentional injury. CPS is one of the focus areas that Tall Pines is developing programming to address.

Maine's Department of Education has increased their focus on walking and biking to school and is working with Safe Routes to School with the Maine Department of Transportation.

#03C. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged
15 through 24 years.

Motor vehicle crashes are the leading cause of death among youth in Maine aged 15-24. Between 2006-2010, 170 adolescents died as the result of a motor vehicle crash, a rate of 20.5 per 10,000. According to data from the 2011 Maine Integrated Youth Health Survey, 14.6% of high school boys and 8.8% of high schools girls never or rarely wore a seatbelt when driving a car or other vehicle, and 10.2% of boys and 6.4% of girls never or rarely wore a seatbelt in a car driven by someone else. Almost 1 in 5 high school students (15.4%) reported that they had ridden in a car in past 30 days with someone who had been drinking; 5% reported they had driven a car after drinking in the past month. Almost half of high school students (41.4%) reported having done other things in the car while driving (e.g., talk on cell phone, eating).

In an effort to address adolescent motor vehicle deaths, the MIPP participates on a Teen Driver Safety Committee. Representatives of this committee include Maine's Office of Substance Abuse, Department of Transportation, AAA, State Police, and the Maine Driver Education Society. This committee recently completed a teen driver strategic plan with BHS that feeds into the overall BHS strategic plan.

In September 2010, MIPP hosted an injury prevention conference with a teen driver focus. A speaker from AAA was featured. In November 2011, Maine hosted the Northeast Transportation Safety Conference, which focused on distracted driving.

Teen driving was selected as a priority area for Maine's Core Injury and Violence Prevention Grant in 2011. As part of this grant, funds will be made available to selected communities to implement evidence-based practices to reduce motor vehicle crashes among teens aged 16-19 years.

Data on teen drivers can be found in the Maine Transportation Safety Coalition's report on Transportation in Maine (http://www.themtsc.org/publications/databook/databook.php), as well as the MIPP annual report. (http://www.maine.gov/dhhs/bohdcfh/inj/data.html).

#04A. The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

Data for this indicator are from Maine's statewide hospital discharge database; 2010 hospitalization data were not available at the time this report was developed. In 2009, 305 children between the ages of 0-14 years were hospitalized for a non-fatal injury. This is a rate of 139.0 per 100,000. Between 2005-2009, the leading cause of injury hospitalization for children aged 14 and younger was unintentional falls. For children aged 5-14 years, the second leading causes were related to transportation (i.e., motor vehicle crashes or other transport). For those aged 1-4 years, the second leading cause of hospitalization was unintentional poisoning.

Unintentional injury was selected as one of Maine's ten MCH priorities for 2010-2015 based on the 2010 five-year Comprehensive Strengths and Needs Assessment. A state performance measure addressing unintentional poisoning among youth under age 24 was created as the result of the selection of this priority. Unintentional poisoning was also selected as a priority as part of Maine's Core Injury and Violence Prevention Grant from CDC.

(See HSI #3A and #3B and the narrative for SPM #5 for activities related to reducing unintentional injuries in the state.)

#04B. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years
and younger.

Data for this indicator are from Maine's statewide hospital discharge database; 2010 hospitalization data were not available at the time this report was developed. In 2009, 29 children between the ages of 0-14 years were hospitalized for a non-fatal injury with a motor vehicle traffic e-code. This is a rate of 139.0 per 100,000. Between 2005-2009, motor vehicle crashes were the leading cause of injury hospitalizations among children aged 5-9 years, and the second leading cause of injury hospitalization among children aged 10-14 years. (See HSI #3B for activities related to this indicator.)

#04C. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24
years.

Data for this indicator are from Maine's statewide hospital discharge database. As noted previously, we did not have access to 2010 data, but in 2009, 146 adolescents and young adults between the ages of 15-24 years were hospitalized for a non-fatal injury with a motor vehicle traffic e-code; this is a rate of 85.8 per 100,000. Motor vehicle crashes were the leading cause of injury hospitalization for youth of this age between 2005-2009. (See HSI #3C for activities related to this indicator.)

#05A. The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Overall, the number of chlamydia cases reported in 2011 represented a slight increase in annual chlamydia counts (2009: 582; 2010: 612; 2011:726). Rates of chlamydia increased in 2011 among girls age 15-19 to 17.4 per 1,000. Rates also increased among women aged 20-44 in 2011 to 6.9 per 1,000. Maine's STD Program is doing targeted testing with females ages 15-24 through their Infertility Prevention Project (IPP) and aims to increase re-screening of those who test positive. To address the increasing rates, the Maine STD Program is also providing treatment at the IPP sites. In addition, the program is following up testing with adequate treatment verification, case follow up for prioritized disease that includes notification of disease,

and partner notification, testing and treatment. Prevention messaging and education are also provided at partner sites. Maine's HIV/STD Program is continuing to conduct targeted testing and treatment and raising awareness of the importance of testing.

#05B. The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

See HSI #5A for more information on this indicator.

#06A & B. Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race,
and ethnicity.

The health status indicator demographic data allow Maine's Title V agency to gauge the scope of the population they are charged with serving. Maine's population is becoming more diverse and the health status indicators allow Title V to track the changing demographics of the population in order to adapt our programs for a broad audience and remain aware of the need for cultural and linguistic competence in our efforts. Data for these indicators are from many programs from around the state and gathering the data has helped to build collaborations across programs.

According to 2011 State-level Census estimates for Maine as of July 1, 2011, 95.5% of Maine's population are white, 1.3% are Black/African American, 0.7% are American Indian, 1.1% are Asian, 0.03% are Native Hawaiian or other Pacific Islander, 1.5% are two or more races; and 1.4% are Hispanic. However, over time Maine's population has become more diverse, and we can see this especially among youth aged 0-24 years. Among those age 0-24 years, Whites comprise 92.2% of the population compared to 96.8% of the population in Maine over age 24; 2.4% of Maine's 0-24 year olds are Black/African American compared to 0.8% of those over age 24; 3.0% of Maine's 0-24 year old population are more than one race compared to 0.9% of the population over age 24. These differences are even higher among the youngest children in the state. Among children age 1-4 years, 90.2% are White, 3.2% are Black and 4.5% are more than one race. A similar pattern is seen for ethnicity, as Maine's Hispanic population continues to increase. Overall, 1.4% of Maine's population is Hispanic. However, among 1-4 year old, 3.1% are Hispanic.

Racial and ethnic diversity is driven in part by the successful resettlement of refugees in Maine. In fiscal year 2010, Catholic Charities of Maine Refugee and Immigrant Services (RIS) resettled approximately 229 primary refugees, 246 secondary migrants and assisted 27 asylees in Maine. RIS is projected to resettle approximately 176 primary refugees in FY2011, with arrivals coming from Somalia, Iraq, Afghanistan, and Eritrea. We expect to see Maine's population continue to diversify in the coming years and many programs within the Maine CDC including the Children with Special Health Needs Program, Maine's Injury Prevention Program, Maine's Oral Health Program, and Maine's WIC program are working to improve culturally competent practices and to engage diverse communities in prevention and intervention efforts. In 2008 Maine WIC received a Special Projects Grant from Food and Nutrition Service to implement a cultural competency training program with staff. Four of Maine's eight WIC agencies participated in this pilot project that included two full days of awareness training and two agency-specific trainings. A report on the evaluation of these trainings was completed in 2011 and presented at the WIC Special Projects Grantee Meeting in Spring 2012. Results from this evaluation indicated that cultural competency training can improve staff awareness and knowledge and change attitudes about how to work with persons from diverse backgrounds.

#07A & B. Live births to women (of all ages) enumerated by maternal age, race and ethnicity.

Among all racial/ethnic groups, the majority of births are among those age 20-34 years. In Maine, the percent of births to women of different racial and ethnic backgrounds is increasing. In 2003, 96.2% of births were to women who were White, compared to 94.0% of births in 2011. In 2011, 2.9% of births were to Black women, compared to 1.2% in 2003. In 2011, 0.7% of births were to

American Indian Women, 1.4% were to Asian women and 1.6% were to women of Hispanic ethnicity.

Data on births to adolescents reveal large disparities within the state. Based on data from 2011, the birth rate for White adolescents was 20.5 per 1,000 females aged 15-19. Among Black/African Americans, the rate was 26.5 per 1,000 and the rate for American Indians was 29.7 per 1,000 live births. The adolescent pregnancy rate among Hispanics was 15.2 per 1,000 compared to 20.9 per 1,000 among non-Hispanics. In collaboration with the Women' Health Coordinator, a Women's Health Report was completed that includes data on live births by age and race and ethnicity for women across Maine.

#08A & B. Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and
ethnicity.

Due to the very small numbers of deaths among youth, it is difficult to draw any conclusions based on these data. In 2010, preliminary data suggest that there were 208 deaths among children and youth age 0-24 years. Ninety-four percent of these deaths (n=198) were among Whites and 3.3% (n=7) were among Black/African American youth. There were no deaths among Asians, three deaths among Native Hawaiian/Other Pacific Islanders, and four among those of more than one race. There were two reported deaths among American Indian youth and one death among those with unknown race. The Maine Office of Health Equity is working to improve collection of race and ethnicity data on Maine's death certificate. Maine has recently adopted an electronic death certificate system and the new standard US death certificate. Maine's Maternal, Fetal and Infant Mortality Panel and Maine's Child Death and Serious Injury Review Panel will continue to review infant and child deaths in the state in an effort to identify systems-level causes and possible solutions to reduce the probability of child death moving forward. In 2009, Maine's Child Death and Serious Injury Review Panel developed a Safe Sleep Campaign Committee to create Public service announcements and other educational materials. The Maine Children's Trust is taking the lead in developing a sudden unexpected infant death (SUID) prevention program.

#09A & B. Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State
programs enumerated by race and ethnicity.

Efforts to obtain data for the HSI forms have increased collaboration across state agencies. This increased contact is leading to improvements in Title V's surveillance capacity. For example, through contact with the Office of MaineCare Services, Maine's Title V has built the foundation for increased access to Medicaid data to link with birth certificate data.

#10. Geographic living area for all resident children aged 0 through 19 years.

In the United States overall, about 19% of the population lives in a rural area. In Maine, 61% of the population lives in a rural area; this presents challenges for accessing health care and providing services. Maine's diverse geography and large size also makes it challenging to understand the needs of Maine residents throughout the state. However, Maine has recently developed a local public health infrastructure through the creation of eight public health districts. By working with the districts, which have an organizational structure that is community-driven, Maine's Title V program is gaining a better understanding of the unique needs and strengths of the different geographies around the state.

The Maine Families Home Visiting Program received funding in 2011 to expand the current Maine Families program to prioritize families living in rural and isolated areas.

#11. Percent of the State population at various levels of the federal poverty level.

According to the 2010 Current Population Survey, Maine's poverty rate of 13% is the 12th lowest in the United States. Maine's childhood poverty rate of 17.6% is the 16th lowest in the U.S., but second highest in New England; 1 in 5 (22%) children under the age of 6 in Maine are living in poverty. With the current economic climate in the state, we don't expect improvement in the state's poverty levels.

#12. Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

See HSI #11 for information.

F. Other Program Activities

Maternal, Infant and Early Childhood Home Visiting Expansion Project

In September 2011 Maine CDC with leadership from the Early Childhood Coordinator in the Office of Child and Family Services was one of nine states that received funding from the federal Department of Health and Human Services, Health Resources and Services Administration (HRSA) to expand and enhance Maine Families, an evidence-based home visiting program designed to improve maternal and child health, reduce child maltreatment, and increase school readiness. Funding from HRSA's Maternal, Infant, and Early Childhood Home Visiting Expansion Grant will be used to increase the number of families served including: those with needs related to substance abuse, mental health, co-occurring disorders, and/or family violence, those in rural areas, and those living in tribal communities; better serve vulnerable families through enhancement of the Parent s as Teachers (PAT) program that includes provision of more frequent visits to families who need them, additional training and clinical supervision for home visitors to better prepare them for engaging and assisting families, and strengthening of coordination and collaboration among local service providers to better serve families in need; increase capacity of all Maine Families sites to participate in data collection and reporting according to federal Benchmark requirements; and strengthen state-level systems collaboration for a coordinated continuum of early childhood services, with home visiting as a sustainable and integral component of the system.

Maine will build on the success and lessons learned from two pilot communities within the state. Washington County's "Bridging Project" led by the Community Caring Collaborative, a coalition of 35 agencies, and the recipient of a LAUNCH grant from the federal Substance Abuse and Mental Health Services Administration was replicated in Penobscot and Piscataquis counties as part of our maternal infant and early childhood home visiting (MIECHV) updated state plan and will be taken statewide as part of the MIECHV expansion grant.

Maine CDC Accreditation

The Maine CDC senior management team identified obtaining voluntary public health accreditation as one of its strategic priorities. The Title V Director was asked to provide leadership in preparing the Maine CDC for accreditation by working with the Accreditation Coordinator. The Maine CDC completed a rapid assessment of the organization's satisfaction of the standards and has a January 2013 goal for submitting the statement of intent for application. The preparation process is on track and the Maine CDC will conduct a mock assessment in October 2012 to gain objective feedback on its preparation to meet the standards, as well as to gain experience in the site visit review process.

Preparation to add SCID

In June 2011 the Department of Health and Human Services Commissioner, Mary Mayhew, accepted the Joint Advisory Committee recommendation to add severe combined immune deficiency (SCID) to the panel of conditions included in newborn bloodspot screening with a goal of implementing it in July 2012. A multidisciplinary workgroup is developing the systems that need to be in place for successful implementation of SCID screening. A definitive date for implementation is pending.

Base Integration Component Grant

In late June 2011 the Maine CDC Injury Prevention Program (MIPP) was notified that it would be one of eight additional states to receive funding through the US CDC's Base Integration Component (BIC) injury and violence grant. This grant enables the MIPP to broaden its focus to look across the lifespan beyond just the MCH population. Through this grant four organizations will receive mini-grants to implement and evaluate an evidenced based intervention that addresses either motor vehicle crashes with teen drivers, suicide in men 40 to 59 years of age, medication misuse, falls among adults 65+, or brain injuries in children less than 1 year of age.

Homebirths

The Maine CDC has signed on to the Association of State and Territorial Health Officers President's challenge to reduce preterm birth and infant mortality. The Title V Director is working with a multi-organizational group to develop a plan that links multiple existing initiatives. A somewhat related emerging issue is the safety of home births by unlicensed midwives. In the last four years there have been several poor outcomes and in June 2009 the Department of Health and Human Services Child Death and Serious Injury Review Panel was charged with conducting a two year retrospective review and a two year prospective review of home births that had significant complications and/or poor outcomes. The retrospective review was submitted in November 2009 and the prospective review was submitted June 2012. The Director of the Maine CDC and the Title V Director are working with a multidisciplinary group to develop a quality improvement process for home births.

Women's Health Profile

In November 2011 the Maine CDC released a Women's Health Report that examined the factors that contribute to women's health and well-being. This report, an update to the 2002 report: Women's Health: A Maine Profile, focused on adult women (18 and older); it includes information on women's access to care, physical and mental health status, reproductive health, substance use and abuse, chronic disease, injury, health activities and use of preventive services. The goal of the report was to provide data on major health concerns among women in Maine in order to inform, educate, and improve women's lives. The report revealed that although substantial gains have been made in ensuring Maine women are healthy, disparities still exist and women continue to face challenges that carry health risks.

MCH Epidemiology Services Request For Proposal

In early FY12, Governor Paul LePage issued an executive order that required all cooperative agreements between the State of Maine and the University of Maine System to be competitively bid unless a specific waiver was granted. The MCH and chronic disease epidemiology services were competitively bid in May 2012 and the University of Southern Maine was awarded the contract. This will permit up to 5 years of continuous MCH epidemiology services which will include the 2015 MCHBG comprehensive strengths and needs assessment.

G. Technical Assistance

Please refer to Form #15. We will request technical assistance from the Maternal and Child Health Bureau and other appropriate entities such as other State Public Health Agencies, Academic Institutions with expertise in public health and public administration, non-profit organizations with MCH/CSHN expertise, and other federal partners such as the Centers for Disease Control and Prevention for the following:

1. Technical assistance from an experienced Women's Health Coordinator to mentor our Women's Health
   Coordinator.
2. Technical assistance on life course theory (LCT).
3. Technical assistance in developing a state plan for adolescent health.

The request for reverse technical assistance (#1) for women's health was selected due to having a new women's health coordinator in a position that had been vacant for approximately a year. The previous coordinator had several grant related projects that have now ended, and with new staff, women's health is in a position to re-energize the work in this area. While there have been some training opportunities at various conferences, we have not identified a national conference that can provide our new Coordinator with a broad orientation to public health efforts in women's health. The opportunity to observe an effective State Women's Health Program and be mentored by an experienced women's health coordinator will assist Maine in developing an effective program while at the same time meet the professional development needs of our staff. The Title V Director will inquire on the availability of the Women's Health Coordinator in Wisconsin, Millie Jones, for this type of technical assistance. The Title V Director will also contact the Women's Health Director at AMCHP for suggestions on Women's Health Coordinators in other states.

The request for technical assistance (#2) on life course theory was selected because we would like to have someone through MCHB or AMCHP come to Maine to educate MCH and chronic disease staff on life course theory and how to use life course theory as a basis in our integration of chronic disease and MCH in the new Division of Population Health. Potential technical assistance providers include MCHB, AMCHP or Johns Hopkins University.

Request (#3) is for technical assistance in developing a state plan for adolescent health. Data used in developing the plan will be utilized in our 2015 comprehensive strengths and needs assessment and the plan will be used to move forward with adolescent health related priorities. A potential provider could be from the Konopka Institute.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	3507118	3243363	3375617		3375617	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	9740069	13864360	10899710		9262438	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	13247187	17107723	14275327		12638055	
8. Other Federal Funds *(Line10, Form 2)*	25211753	25230035	22159465		10270003	
9. Total *(Line11, Form 2)*	38458940	42337758	36434792		22908058	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	557389	760737	626440		566234	
b. Infants < 1 year old	3601134	4830187	3933377		3605322	
c. Children 1 to 22 years old	4259021	5035599	4498973		3762700	
d. Children with	2068642	2941129	2308141		2126313	

Special Healthcare Needs						
e. Others	2528242	3194029	2675637		2312355	
f. Administration	232759	346042	232759		265131	
g. SUBTOTAL	13247187	17107723	14275327		12638055	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	933017		1580701		8726372	
b. SSDI	60097		0		65357	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	22344668		18977490		0	
h. AIDS	0		0		0	
i. CDC	275185		175000		152000	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
Family Planning	0		0		410274	
SANHSA	0		0		916000	
SAMHSA	1416000		1016000		0	
SS FAMILY PLANNING	0		410274		0	
FAMILY PLANNING	110274		0		0	
HGWY	72512		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	7174772	8935155	7729053		6573768	
II. Enabling Services	936386	1108374	899199		840121	
III. Population-Based Services	1785580	2200539	1900562		1616289	
IV. Infrastructure Building Services	3350449	4863655	3746513		3607877	
V. Federal-State Title V Block Grant Partnership Total	13247187	17107723	14275327		12638055	

A. Expenditures

For a summary of any variances please refer to Section VB - Budget.

B. Budget

The Division of Family Health expended $17,107,723 for maternal and child health services in FY11, including $13,864,360 of state funds and $3,397,305 of Title V funds. Expenditures by

populations served include 57% ($9,865,786) expended on primary care and preventive services for children; 18% ($2,941,129) expended for children with special health needs; 4% ($760,737) expended for pregnant women; 19% ($3,194,029) for others; and approximately 2% ($346,043) for administration. The "other" category is comprised primarily of women of reproductive age who are not pregnant or recently postpartum. In FY11 there was an increase in expenditures primarily due to grants related to the Affordable Care Act (ACA), Maternal Infant Early Childhood Home Visiting (MIECHV) and Personal Responsibility Education Program (PREP). The CSHN Program continued to reallocate expenditures away from direct services due to the Program's shift from a primary focus on direct services to a community-based system of services.

Delineating expenditures by levels of the MCH Core Services Pyramid, 52% ($8,935,155) was expended on direct services; 6% ($1,108,374) on enabling services; 13% ($2,200,539) on population based services; and 29% ($4,863,655) was expended on infrastructure building services. In FY 11 there was an increase in expenditures over budgeted with the most increase in the direct services and infrastructure levels of the MCH Pyramid. Programs included in the calculation of direct services include MIECHV, family planning, genetics, public and community health nursing, and oral health (school based oral health programs including sealants). These direct services are paid for with state funds that are the match to the block grant not with federal block grant funds.

In FY13 the Division proposes to spend $3,375,617 of Title V funds, with no carry forward from FY12. Of the Title V funds, 55% ($1,879,935) is allocated to primary care and preventive services for children; 37% ($1,230,551) to children with special health needs; and 8% ($265,131) is available for administrative expenses. Considering the total federal and state budgets, the Division proposes the following expenditures, categorized by level of the MCH Core Services pyramid: 52% ($6,573,768) will be allocated for direct services; 6% ($840,121) for enabling services; 13% ($1,616,289) for population based services; and 29% ($3,607,877) for infrastructure building services.

The FY13 budget is $1,637,272 less than FY12 primarily due to cuts to the MCHBG match. Included in the annual MCHBG budget is approximately $70,000 to cover expenses related to out of state travel to attend regional or national meetings that are important in advancing the health of Maine's MCH population. The following meetings and conferences are the range of MCHBG related meetings that staff may attend. The Maine CDC will NOT send staff to all of the meetings on this list.

Regional and national meetings staff will attend during FY13 include: MCHB Partnership, Association of Maternal Child Health Programs, American Public Health Association, National Association of School Based Health Centers, National Network of State Adolescent Health Coordinators, Association of State and Territorial Dental Directors Partners, Federal CDC Division of Oral Health State Dental Directors' Workshop, Society for Adolescent Medicine, Association of Public Health Nurses, New England Regional Genetics Group, National Newborn Screening and Genetic Testing Symposium, National Women's Health Coordinators, State and Territorial Injury Program Directors Association, American Cleft Palate Association, National Birth Defects Programs, National Perinatal Association, Newborn Bloodspot Screening, American Evaluation Association, Region I MCH and CSHN Directors, on-site Public Health Prevention Specialist interviews at Federal CDC, Women's Health Summit, March of Dimes Annual Meeting on Quality Improvement to Prevent Prematurity, Annual New England Birth Defects Consortium, Cleft Lip and Palate Symposium, National Improvement Partnership Network, Child Health Insurance Program Reauthorization Act meetings, Association of State and Territorial Health Officials Accreditation, Boston University School of Public Health MCH Advisory Board, New England Health Resources and Services Administration Continuing Education Collaborative, CDC Core Injury Surveillance, Safe States, Substance Abuse and Mental Health Services Administration, National Highway Traffic Safety Administration Crash Outcomes Data Evaluation System Grantee, National Violent Death Reporting System, Region I Women's Health Workgroup as well as the Society of State Directors of Health, Physical Education, and Recreation and the

American Alliance for Health, Physical Education, Recreation and Dance, and Regional and National meetings related to accreditation preparation. Maine will send the Title V Director, CSHN Director, and Division of Population Health Medical Director to the AMCHP and MCHB Partnership meetings and will send the Title V Director and Maine Families Home Visiting Manager to the National Home Visiting Summit.

Conferences include: MCH Epidemiology, American Association of Suicidology, MCH Leadership Institute, Leadership Enhancement in Adolescent Health, Life Savers, Region 1 Minority Health, Public Health Nursing Informatics, and conferences or meetings that are needed as a part of the orientation of new staff and for staff development.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.